

The Interactive Effects of Key Influencers on Mental Health in the Workplace: A Conceptual Framework

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A Theoretical Framework for the Interactive Effects of Key Influencers on Mental Health in the Workplace

ABSTRACT

Declining mental health in the workplace presents organizational decision-makers with serious challenges because it detracts employees from **their** job performance and **hurts** organisational effectiveness. From an economic perspective, the direct and indirect costs of diminished employee mental health are huge and predicted to rise **in future**. Prior research indicates that the interactive effects between **public** policy and organizational actions have a positive impact on mental health in the workplace as well as for society as a whole. Affirmative (proactive) action can improve the mental well-being of employees and positive psychology moderates the relationship between the incidence of mental health in society and the workplace. An effective solution to this growing problem requires **public** policy-makers and organizational decision-makers to collaborate. This paper identifies a range of current and emerging issues related to mental health in the workplace and presents a theoretical framework to provide a suitable platform for future empirical research in this area.

Keywords

Mental health, public policy, conceptual, framework, organization, well-being, consequences, positive organizational scholarship, workplace, world health organization

INTRODUCTION

“...mental 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 et al., 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 World Health Organization (2013), at least 450 million people suffer from mental health problems in both developed and under developed countries. United Nations estimates that 25% of worlds’ population experience a mental health episode during their lifetime, which is both a cause and a consequence of, major socio-economic problems such as, poverty, compromised education, gender inequality, ill-health and violence, among others (United Nations, 2010). Globally, some 3-4% of GNP is estimated to be spent on problems related to mental health within the workplace (World Health Organization, 2003). 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, we need urgent attention and actions to help curb this growing problem.

Dealing with poor mental health in society should be viewed equally as a policy and workplace problem because 1-in-10 employees are estimated to suffer from depression, anxiety, stress or burnout in the European Union, US, Canada, and Australia, during their working lives (Gabriel and 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 et al., 2010, Love et al., 2010, Pasca and Wagner, 2012, Puig et al., 2012, Travers and 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 dealing with inherent organizational problems, one promising avenue of research in explaining how to address mental health issues, relates to how positive actions can yield effective individual and organizational outcomes (e.g., Cameron et al., 2011, Gabriel and 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 **interventions** can contribute to the well-being 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. A healthy workforce signals a healthy society, hence both policy and managerial decision-makers stand to gain through collective action designed to improve individual mental health in the workplace.

In this respect, policy and organizational initiatives are like two sides of the same coin. Accordingly, both parties will need to be cognizant of the impact mental health potentially has within, and on each other's sphere of influence, prior to developing and implementing any effective strategies directed at improving the situation. With that notion specifically in mind, the main aim of this paper is to synthesise 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. **Therefore**, we begin by arguing that mental health has no physical boundaries (Kitchener and Jorm, 2004) and the variety of afflictions permeate many facets of people's lives, as well as their workplace, institutions, and broader society.

With this in mind, **we include the four elements of mental health, namely personal well-**

being; coping, symptoms and disorders, within the *Nature & Extent of Mental Health* domain in our framework. Based on our review of the available literature, we posit that these four elements influence and are 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 to infer how mental health problems in society has a range of consequences for organizations, vis-à-vis. Within the framework are propositions that are suitable for testing. We also introduce a conceptual framework (figure 1) to provide a better understanding of the potential role that government, societal entities, and organizations can play in helping to deal with poor mental health.

< Insert figure 1 about here >

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 & Extent of Mental Health, Positive Organizational Scholarship, Societal & 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 societal mental health problems. In the following sections, we explore the magnitude and cost of mental health problems within the society and the workplace, links between Positive Organizational Scholarship 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 was scrutinised using the following keywords - mental health, public policy, conceptual, framework, organization, well-being, consequences,

positive organizational scholarship, workplace, world health organization. A substantial number of high quality reports into mental health were identified from Europe, United Kingdom, 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 US Department of Health and Human Services. Next, we 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 well-being* 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 health conditions characterized by alterations in thinking, mood, or behaviour (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 focussed description of mental health, in relation to work. This model synthesises 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: 132) introduces twelve 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; 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 and 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 ultimate aim 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 potential solutions.](#)

Cost of workplace mental health

[Mental health problems in the workplace are not a new phenomenon and 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 justices and social security systems \(Knaap, 2003\). These direct as well as indirect costs of mental health have been on the rise for decades. In this regard, there is unequivocal evidence that the global financial cost from negative aspects of mental health is debilitating for both industry and society. This cost has increased significantly and is estimated \(predicted\) to substantially increase over the last few decades. For example, the estimated cumulative global economic output lost to mental disorders will amount to US\\$16.3 trillion between 2011 and 2030 \(Bloom et al., 2011\).](#)

More than a decade ago, the cost of stress at work, and related mental health problems in the European Union (EU) alone was estimated to average between 3% to 4% of gross national product, amounting to €265 billion annually (Levi, 2002). During 2000, a survey of the then 15 EU member states found over half of its 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 (UK) stress, depression or anxiety was the largest contributor to the overall estimated annual days lost due to work-related illness (Tasho et al., 2005). The British economy lost approximately 3.5% of GDP per annum, equating to £40GBP billion per year on stress-related illness (Toohey, 1995). In the same period, work-related stress alone cost businesses and governments across the EU 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 UK, time off work for stress related illnesses has increased by 500% since the 1950s. In 2003, over half a million Britons believed they experienced work-related stress that made them ill (Jones et al., 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 the chronology of this growing problem on 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 remains unresolved. About 1 in every 20 working aged Britons experience major depression at any given point in time (Gabriel and Liimatainen, 2000) impacting the public funds and industry.

In Australia, 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 and 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 1985-86, to 5.1% in 1997-98. At the time these were estimated to double by 1992-97, costing the economy in excess of \$AUD200 million annually. Current expenditure was almost \$6.9 billion (or \$309 per person) for the 2010-11 period, an increase from \$238 per person since 2006-7 (Australian Institute of Health and Welfare, 2013). Recently, an estimated 1.9 million Australians (9% of population) received mental health services during 2010-11, including 15 million mental health related general practitioner visits in 2011-12 (Australian Institute of Health and Welfare, 2013). Similar patterns are observed in the US 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 US, with costs estimated to range between \$US30 and \$US44 billion per annum to treat (Gabriel and Liimatainen, 2000). These authors also report that 1-in-10 working age American 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 \$US25 billion a year in absenteeism and low productivity, and a further \$US15 billion for treatment (Moskowitz, 1998).

Clearly, such attitudes need to change **because a failure** to take responsibility for employee well-being **will have both, a wider long-term as well as a** more immediate range of negative

consequences for organizations. In fact, the employers have a duty to take care of their employees in the workplace and protect them from injuries derived through physical and/ or psychological well-being (Cooper and 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 pre-existing conditions, or (3) a combination of either because as indicated earlier, reduced mental health levels within their workforce will lead to losses in employee productivity and performance. Therefore, it is imperative that the organizations will need to play a greater role in helping to find solutions to these seemingly intractable problems. Given the nature of the mental health challenge it is evident that the best approach to take would be to ensure organizational policy and procedures concurrently serve the best interests of both organizations and its employees.

Positive Organizational Scholarship and mental health

Based on the previous, we argue for shifting the focus to exploring the positive view of the mind (Cameron and Caza, 2004, Snyder and Lopez, 2002) has the potential to contribute to the explanation how organizations can respond to many mental health challenges. This approach will also help inform managerial actions designed to simultaneously serve organizational and employee interests. Our argument extends the positive organizational scholarship (POS) domain, which helps explain and predict the occurrence, causes, and consequences individual, group and organizational and mental health issues. We reinforce the main thrust of POS in relation to mental health as it also underpins our thinking.

Positive scholarship attempts to explore how an individuals' quality of life can be enhanced, particularly those who work within, and are affected by, organizations (Roberts, 2006). POS is conceptualised 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). POS can explain how the 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 identified in the literature to help improve mental health and individual well-being. For example, there is a positive association between workforce participation and elevated psychological well-being is well established (Dooley et al., 1996, Mathers and Schofield, 1998).

POS is the study of dealing with positive “outcomes, processes and attributes of organizations and their members” (Cameron et al., 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 in to improve the mental health of their employees. Typical examples of POS studies include exploring the effects of positive affect; organizational citizenship behaviours; psychological capital; and, prosocial behaviour (Avey et al., 2010, Baruch et al., 2004, Castro et al., 2003, Mayfield and Taber, 2010, Sun et al., 2007) within organizations.

Such practice and scholarly endeavours in relation to POS focus on understanding those dynamics associated with and leading to developing human strength that produces resilience, restoration and vitality. It is 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 and 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 need to taking a proactive approach. This necessitates organizations take positive affirmative action. Whilst we do acknowledge the

critics of positive scholarship (e.g., Fineman, 2006, Held, 2004), research in this domain are potentially yields individual and organizational benefits associated with managerial action.

Cameron et al. (2011) reveal [that](#) positive organizational practices help elevate 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 well-being, and this provides a further indication of the role of positivity within organizations \(Luthans et al., 2007, p. 542\).](#) 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. In this context, Lyubomirsky et al. (2005) found that happy people tend to acquire more favourable life circumstances which engender success, holding across multiple life domains, such as marriage, friendship, health and job performance.

Clearly, there is merit in building programs within the work setting that stimulate and foster happiness and positivity among employees. The potential organizational benefits of cultivating these are well documented (Pressman and Cohen, 2005, Seligman and Csikszentmihalyi, 2000), indicating organizations should propagate happiness, wellbeing, courage, citizenship, healthy work, and healthy working relationships. We conceptualise such positive action within the workplace in terms of actions designed to enhance self-confidence and dignity, nurturing well-being and happiness, as well as promote employee excellence. Collectively, these comprise elements of the POS domain within our framework (figure 1).

The literature strongly indicates that the key to unlocking an individual's full potential and subsequent mental well-being is through such forms of constructive managerial actions.

Critics also argue that the POS approach is merely self-centred on the part of decision-makers (e.g., Fineman, 2006, Roberts, 2006) but we advocate this positive approach has merit for a number of reasons. Any effort to help reduce individual suffering can, and should be a prime organizational concern. The question of being self-centred (if it indeed arises) is a separate issue to the real problem at hand. That is, reducing individual suffering from mental health. Put simply, 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 empower to help others within the community (Hickie, 2004, Menhenhall and Jackson, 2013).

Contemporary research in occupational psychology centres upon incorporating happiness, wellbeing, courage, citizenship, and satisfaction with healthy work and healthy relationships (Cameron et al., 2003, Keyes and Haidt, 2003). There is growing resistance in psychology to obsessing over the dark side of human existence – directed towards a more positive view of the mind (Cameron and Caza, 2004, Snyder and Lopez, 2002). Such intense enthusiasm for POS is naturally to be 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 sufferance. Both belong to the human narrative. Seligman (www.edge.org) tempers the case for POS by recognising 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 conceptualisation suggests addressing mental health can be approached from either the 'positive' or 'negative' vantage as either is simply attempting to provide a remedy to one side of the same coin.

'Happier-and-smarter' and 'sadder-but-wiser'

Interest in 'happier-and-smarter' ('enthusiasm-naivety') and the 'sadder-but-wiser' ('depressive-realism') hypotheses (Staw and Barsade, 1993) may therefore be seen within the broader context of research efforts directed towards POS. Staw and Barsade's (1993) 'happier-and-smarter' and the 'sadder-but-wiser' hypotheses are integral to any discussion pertaining to POS. These authors find a positive relationship between dispositional affect and employee performance. On the other hand, 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 judgements compared to their less depressed counterparts. In this conceptualisation, emotional behaviours have the potential to facilitate, interfere or are simply unrelated with behaviours in the job domain Weiss and Cropanzano (1996). Indeed, reactions to negative events produce stronger reactions than [the reactions to](#) positive experiences (Taylor, 1991).

Positive moods are more likely to engage in simplified heuristic processing when making judgements and decisions (Sinclair and Mark, 1992). Those in a negative mood are likely to be more prone to utilising systematic information processing strategies given individuals reporting negative affect tend to focus attention to improving the quality of decisions made (Forgas, 2002, Schwarz and 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 et al., 1982, Martin and Stang, 1978) and the illusion of control (Langer, 1975). As such, individuals who are less positive exercise more accurate information processing (Weiss and Cropanzano, 1996). **For example**, a person with depressive tendencies is less likely to overestimate their capacity to deal with ambiguous task circumstances (Tabachnik et al., 1983). Such a counter-intuitive position regarding the possible decrements in performance resulting from the emotion-performance relationship is likely to be contentious.

Overall, a common theme has emerged from the Canadian and Australian experience of 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, all three tiers of government have usually been responsible for mental health policy, program and services. There is considerable overlap between service provision between the government, private and not for profit sector. These services are delivered either directly or by outsourcing to private agencies capable of providing enduring holistic solutions (Rosenberg and Hickie, 2013). Evidence 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 will be effective for consumers. In particular, mental health needs to overcome the existing policy silos to overcome a complex system that is “characterised by fragmentation and inconsistency” (Rosenberg and 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; socio-cultural, 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 a Mental Health Action Plan 2013-2020 to promote global mental well-being, 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, consistent with their national priorities and specific circumstances. There is no universal grand plan to solve global mental health problems because 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 programmes designed to promote the mental well-being of its 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 to promote mental health. One of the successful spin-offs of the strategy was been the formation of the independent, not-for-profit public entity *beyondblue*, whose key priorities include: (1) increase awareness of depression and anxiety, (2) reduce stigma and discrimination, (3)

improve help seeking, (4) prevention and early intervention, (5) reduce impact, disability and mortality, and (6) facilitate learning, collaboration and research (Beyondblue, 2013). At inception, this was a new national collaborative model, initially funded by the Federal and Victorian Governments with \$17.5 million each 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 MHFA courses developed in 2000, developed and offered by the Centre for Mental Health Research, Australian National University. The main reason for developing the course was to help those many sufferers in workplaces that wait far too long before they seek help. This program 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). Thus, it is a more direct type of affirmative action and specifically targets sufferers. The course has been so successful that it is now replicated worldwide (Menhenhall and 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 targeted employment initiatives (Jorm and Kitchener, 2011). The MHFA can be tailored and align with the various national and state level priorities and capabilities in each jurisdiction. Major, outcomes from the course, include increased mental health knowledge, decreased stigma, and increased confidence in helping a person when having a mental health crisis (Menhenhall and 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 healthcare experts and economic policy leaders declared their first ever Business Year for Addiction and Mental Health forum. Through this forum a charter aimed at mobilising key stakeholders, namely trade unions and employers in the private and public sectors, through national and international efforts, aimed at preventing the debilitating effects of workplace depression, anxiety and addiction was proposed. The Mental Health Commission of Canada has now developed a national standard with the aim of providing a systematic approach to develop and sustain a psychologically health workplace (Mental Health Commission of Canada, 2013). The Canadian plan comprises three strategic pillars, namely prevention, promotion and resolution that attempt 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, among others, unions, employer groups and employers. Such involvement from senior organizational leaders, unions and employer groups are crucial to ensuring the psychological well-being of the work force (Gilbert and Blisker, 2012). Inputs and support from these stakeholders are tantamount for such programs to gain traction.

CONCEPTUAL FRAMEWORK AND CONTRIBUTIONS

Drawing upon the existing frameworks described in the previous section, we posit that organizational actions, depicted through POS and various national policy frameworks and initiatives, encapsulated by the various *Societal & Institutional Frameworks* are highly interdependent. The effects of these domains on one another and their moderating powers on the recursive relationship between mental health and organizational consequences are reflected in our conceptual framework which provides an overarching perspective on how to

juxtaposition 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. An individual's mental well-being has become analogous to the workplace and society. In an effort to help understand the problem, we have synthesized the literature and articulate a framework that contextualizes the nature and extent of poor mental health in the context of these domains. The main scholarly contribution is four-fold.

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 comprising *Nature & Extent of Mental Health*, *Positive Organizational Scholarship*, *Societal & Institutional Frameworks* and *Organizational Consequences* domains. 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 the problem. Through this the inference can be made that 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 them in detail herein 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 organization's response (or lack of) to the mental health challenge is central to finding solutions to this conundrum.

Since organizations are seen to be both *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 *Positive Organizational Scholarship* and *Societal & Institutional Frameworks* potentially enhance (dampen) the positive (negative) outcomes. Fourth, the framework shows the relevance of drawing on POS to help explain how affirmative action can help find solutions to mental health problems. Our synthesis of the literature reveals that a healthy workforce usually equated to (means) a healthy society, and vis-à-vis, so affirmative action by organizations under the auspices of POS is seen herein to have widespread benefits.

Available studies in this domain are largely descriptive in nature, thus appropriate cause-effect models with pertinent constructs would be most beneficial. This is because research findings potentially help policy and organizational decision-makers decide on *how* and *where* they can direct their limited resources to maximum effect. Third, there appears to be no systematic examination in the extant literature as to what types of work places (and role types) lead to the recursive relationship between mental well-being 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 seemingly an inadequate explanation. A typology comprising various professions and the mental health consequences of each work setting is worth exploring in more detail. Employers therefore must become ever vigilant and ensure its decision-makers are cognizant of mental health problem, its likely consequences for the individual and organizations, and perhaps more importantly, what they can do about it. However, lessons still need to be learned on how to prepare organizations to deal with growing cases of ailments such as stress, depression and anxiety in the workplace.

Ultimately, the framework developed here 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. This would minimize wasteful use of limited resources in trying to develop programs for non-existent problems. Fourth, our framework indicates how affirmative action, under the semblance of POS, can help improve the mental well-being 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 should be a research priority. The success of MHFA program shows the value in (affirmative) proactive action on mental health outcomes (Menhenhall and Jackson, 2013, Terry, 2010, Zilnyk, 2010) but since research may uncover a much wider range of options in the repitour 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 recognise that the sheer scale and scope of poor mental health within society means that it will inevitably afflict their work environment. These means organizational decision-makers also need to play a role in formulating viable solutions to the problem. Executives and managers need to realise 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 vitreous 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 also indicated to be 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 available studies. Our framework highlights the positive possibilities of various organization actions for improving mental health but empirically generalizable studies in this area are scant. Sutton, Hocking, and Smythe (2012, p. 143) noted, that despite the view in the literature that "occupation is beneficial for mental well-being, there is limited research exploring the experience and meaning of occupation in the context of the recovery process". The direction and strength of the link between affirmative organizational action and its association with positive mental health outcomes, vis-à-vis, therefore needs to be empirically established across settings.

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