

Workplace Antistigma Initiatives: A Scoping Study

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Objective: The purpose of this scoping study was to identify and describe the principles and characteristics embedded in workplace mental health antistigma initiatives. Research in this area is diffuse and not well synthesized. Therefore, a scoping study is useful in generating a breadth of coverage and identifying all relevant literature on the topic regardless of study design. Results will inform evaluation strategies and can be used to distinguish the effectiveness of particular elements in future research.

Methods: The “York Framework,” a five-stage methodological design (with an optional sixth stage) was used as the structure for this study. Eleven peer-reviewed and gray-literature databases were searched (2000–2011), and an extensive Internet review was also conducted. Two reviewers independently reviewed all abstracts to determine study selection. A data chart consisting of key issues and themes was utilized to extract data from the included studies. Preliminary results were used to inform a stakeholder consultation with seven international experts.

Results: Twenty-two antistigma interventions were included in the study. Most of the initiatives have appeared in the past four years and across geographic boundaries, reflecting the growing international interest in mental health in the workplace. A large proportion of the interventions utilize educational approaches to reducing stigma, and a substantial number target military personnel. **Conclusions:** Stronger evidence for effective practices needs to be established through the use of standardized workplace-specific interventions, reliable and valid evaluation tools, and overall enhanced scientific rigor. (*Psychiatric Services* 64:694–702, 2013; doi: 10.1176/appi.ps.201200409)

Increasingly, the workplace is viewed as a domain in which mental health problems occur and, accordingly, the context in which they must be addressed. Costs related to poor mental health in the workplace are rising because of increasing staff absenteeism, presenteeism (lost productivity while at work), and premature withdrawal from the workforce. Statistics from the United Kingdom suggest that 11.4 million working days were lost in 2008 and 2009 because of work-related stress,

depression, or anxiety (1). Research in the United States estimated that an average of 27 working days were lost per year per employee with depression, representing an annual loss of US\$36.6 billion (2). Canadian estimates have attributed \$4.5 billion (CAD) in annual work-related productivity losses to depression alone, with disability claims accounting for up to \$33 billion (3). In addition to the significant economic costs associated with mental health problems in the workplace, there are considerable

social costs. Having a mental health issue is predictive of unemployment and reduced career goals, which result in a decrease in quality of life and diminished community participation (4).

In light of the growing awareness of the relationship between work and mental health, the workplace has increasingly become a site of mental health promotion, illness prevention, and intervention. Interest in both organizational and individual-level interventions to reduce worker stress and promote mental health is growing. Although there is evidence to support various strategies to promote workplace mental health, review studies investigating specific group, organizational, and environmental approaches have failed to establish conclusive findings regarding impacts of worker and organization interventions (5,6).

Adding to the complexity of mental health issues in the workplace is the impact of stigmatizing attitudes toward and beliefs about mental illness. Stigma has been identified as a primary barrier that prevents individuals from participating fully in the workplace (7). Individuals with mental health problems experience both public and self-stigma (4,8). Public stigma has been defined in terms of three components that have a negative impact on the lives of individuals living with mental illness: stereotypes, prejudice, and discrimination (9). Self-stigma refers to the internalization of stigma, which can result in diminished self-esteem and reduced self-efficacy (10). Stigma in the workplace includes elements of both public and self-stigma. As a result, individuals with mental illness experience a high level of

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unemployment and underemployment (4) and thus frequently experience employment inequity and discrimination (11). Although the need for workplace interventions has been recognized, approaches to implementing them are diverse and research on their impacts is limited. There is a need to better understand methods that maximize approaches to combating workplace stigma and that lead to effective change (12).

Recent research has shed light on effective components of antistigma initiatives. A meta-analysis of studies investigating public stigma reported that both contact and education were widely used intervention strategies; however, contact was better than education at reducing stigma among adults (13). This study also called for an increased focus on behavioral outcomes over both psychological changes and moderators of antistigma programs, such as the medium in which contact- and education-based strategies are delivered. Similarly, a review of strategies to reduce self-stigma demonstrated that leading approaches utilize interventions that enhance coping skills through improvements in self-esteem, empowerment, and help-seeking behavior; however, the authors called for greater attention to self-stigma conceptualization, measurement tools, and theoretical frameworks (14).

Although evidence is emerging about strategies and approaches to combat public stigma and self-stigma, the effects of workplace antistigma programs have not been adequately evaluated. Krupa and colleagues (7) developed a model with several key components regarding stigma in the workplace. These components include the consequences of stigma (such as marginalization), the assumptions underlying the expressions of stigma (such as incompetence and dangerousness), and the salience of these assumptions, both to the people holding them and to the specific employment situation. Mass antistigma approaches have demonstrated limited sustained effectiveness (15–18), and thus this model is important because it can facilitate the development of tailored strategies that are relevant to specific workplaces.

A preliminary review of the range and nature of workplace antistigma initiatives has been conducted (19), but no systematic investigation has been undertaken of the principles and intervention characteristics that underlie these initiatives. The purpose of this scoping study was to identify and describe the principles and characteristics embedded in workplace mental health antistigma initiatives documented in peer-reviewed published literature, gray literature, and Internet-based sources. To identify components of workplace antistigma interventions, the following research question was used: What principles and characteristics are embedded in workplace mental health antistigma initiatives? An enhanced understanding of these components will aid in the provision of recommendations for improving current workplace antistigma initiatives and will provide direction for future initiatives.

Methods

A scoping study methodology was utilized because this approach maps fields of study where it is difficult to visualize the range of material that might be available (20). Research in the area of workplace antistigma initiatives is diffuse and not well synthesized. Therefore, a scoping study is useful in generating a breadth of coverage and identifying relevant literature regardless of study design (20). This approach is well suited to investigating the various components of antistigma initiatives that are emerging in the workplace setting, because there are no standards or established inventories of such programs.

The five-stage methodological framework (with an optional sixth stage) proposed by Arksey and O'Malley was used as the structure for this study (20). Known as the "York Framework," this process involves identification of the research question; identification of relevant studies; study selection; charting the data; collating, summarizing, and reporting the results; and finally, a consultation exercise. Recommendations to advance the methodology were incorporated at each stage (21).

Stage 1: identifying the research question

The following research question was developed after reviewing the literature and in consultation with experts in the field: What principles and characteristics are embedded in workplace mental health antistigma initiatives? The terms "principles" and "characteristics" are broad enough to capture the various components of antistigma initiatives regardless of the stated (or unstated) theoretical construct.

Stage 2: identifying relevant studies

An initial search strategy using the terms "stigma," "mental health," "intervention," and "workplace" yielded minimal results. The search terms were then expanded in an iterative process by using words located in the abstracts and keywords sections of the articles that were initially retrieved. In total, 11 databases were searched by using the OVID, EBSCOhost and ProQuest search platforms. [Tables presenting data on the search strategy and results on each platform are available online as a data supplement to this article.] An Internet search was also performed by using a combination of the key terms; the first ten pages of retrieved items were reviewed for relevant material. All interventions found via the Internet were cross-referenced with the database search.

Preliminary findings from the study served as a foundation to inform stage 6, the recommended consultation exercise (21). A panel of seven stakeholders—representatives of academia and the military and experts in the field from Australia, Canada, the United Kingdom, and the United States—were asked to provide feedback regarding the results of the study. The consultation exercise was conducted to gain insights relevant to the study, seek additional references or initiatives, and provide an opportunity for knowledge transfer (20,21).

Stage 3: study selection

A number of inclusion criteria were used. The article had to identify the workplace as the site of intervention; the intervention objectives were specific to decreasing stigma toward mental health problems; the publication

and accessibility date was between 2000 and 2011; the source was either gray literature, peer-reviewed literature, or a non-peer-reviewed source (print or electronic); and the recipient group of the antistigma program was workers or employees between the ages of 18 and 65. Excluded were antistigma initiatives delivered to service providers that aimed to decrease stigmatizing attitudes of service providers toward service users (for example, clinicians toward clients or teachers toward students).

Stage 4: charting the data

A directed qualitative content analysis process was employed to capture relevant information for the data chart (21,22). The coding categories were refined in an iterative process. Relevant information was captured across 11 coding categories, which included authors and organizations, date, title, geographical location of the research, workplace setting or industry, goals of the antistigma intervention, type of stigma intervention (for example, education, contact, or protest), duration or frequency of the intervention, study or target population, aim of the study, design, outcome measures, and effect of stigma. Data from each article and Internet program were extracted and reviewed for accuracy by two individuals. These data formed the basis of analysis (20).

Results

Two reviewers evaluated a total of 4,134 unique references against the inclusion criteria. A total of 22 citations were utilized for data collection in the scoping study. [A figure illustrating the selection of articles is available in the online data supplement.] Ten articles were retrieved from the electronic database search, and 12 initiatives were identified from the Internet. The majority of initiatives were from the United Kingdom (seven), followed by Canada (six), the United States (five), and Australia (four). Table 1 provides an overview of the main categories of interventions. The results are summarized in five major categories: workplace setting or industry, specific antistigma goals, type of stigma intervention, duration or frequency of the intervention, and study or target population.

Workplace setting or industry

All but one of the ten antistigma interventions retrieved from the electronic database were directed toward employees and targeted frontline workers. The exception was the intervention described by Orsingher and colleagues (23), who also included senior leaders and senior officers in their interventions. A diverse range of workplace settings was found for the ten interventions that were retrieved from the electronic database, including telecommunications (24), health care (25), and governmental agencies (26,27). Notably, six of the ten interventions targeted armed forces and law enforcement, five were military initiatives (23,28–31), and one focused on police services (32).

Study or target population

For the 12 reviewed Internet programs, the target population was primarily defined in terms of employer and employee interventions. Five interventions specifically targeted the employer, the manager, or human resource professional (33–37). An additional five programs provided antistigma interventions to support both employers (or management) and employees (38–42). The remaining antistigma interventions targeted employees (43), or the description stated only “participants” as the target population (44). Some of the interventions from the Internet suggested involvement at the organizational level, and the articles formulated recommendations in the context of prevention strategies, legal responsibilities, practices for promoting mental health, and resources for raising awareness (33,34,36,40).

Type of stigma intervention

Thirteen initiatives described direct workplace interventions, such as workshops or seminars (26,27,29–35,37,38,43,44). Types of interventions can be discussed in terms of direct and indirect approaches. Interventions that are delivered face-to-face within the workplace are referred to here as direct approaches, whereas the provision of workplace antistigma resources and materials through Internet access are referred to as indirect approaches. One initiative offered both

direct and indirect strategies (40). The remaining eight provided only indirect strategies (24,25,28,36,39–42). Only one direct intervention strategy included in-person contact with individuals living with mental health issues (the intervention utilized by both Knifton and colleagues [27] and Quinn and colleagues [24]). Six other interventions included videos of persons experiencing mental health issues (23,25,33,39,42,43). The remaining direct intervention techniques utilized primarily education as a strategy, which was operationalized in the form of workshops, psychoeducation, lesson plans, or experiential group learning.

With the exception of the peer-to-peer strategies, direct interventions were provided once and varied in duration from 45 minutes (33) to 2.5 days (31), with a majority lasting less than nine hours of total intervention time. There were no direct intervention strategies at the organizational level from the perspective of institutional practices, processes, or procedures, and no mention of a long-term sustainability or capacity-building component. Overall, no common theme emerged to support one particular type of intervention or duration over another.

Four programs utilized a peer-support approach (23,28,29,32). These programs used different interpretations of the term “peer support.” In the study by Grenier and colleagues (29), peer support referred to colleagues with lived experience of mental illness. Orsingher and colleagues (23) utilized a “battle buddy” (defined as a person who knows exactly what the soldier is experiencing because he or she is having or has had a similar experience). Dowling and associates (32) and Greden and colleagues (28) used the term to refer to recruited and trained volunteers from within the police force and military; in these cases peer support did not necessarily involve individuals with lived experience of mental illness.

Outcome measures

Five of ten studies retrieved from the electronic database reported a positive effect in terms of reducing stigma or stigma-related behaviors (24,26,27,31,32), whereas positive

Table 1

Characteristics of workplace antistigma interventions reviewed in the scoping study

Author or sponsor organization	Country	Workplace setting or industry	Specific antistigma goals ^a	Type of stigma intervention	Duration or frequency of intervention	Study or target population
beyondblue (33)	Australia	State, territory, and local governments, large corporate organizations, “blue collar” industries, small and medium enterprises, not-for-profit organizations, professional associations, professional sporting bodies, rural businesses	Decrease stigma by improving attitudes toward people experiencing anxiety and depression	National Workplace Program: a series of 5 workshops, including DVD case studies and structured discussions	Workshops range from 45 minutes to 4 hours	Senior executives, managers, general staff
Canadian Mental Health Association Calgary (44)	Canada	Corporate community	Define and demonstrate the effects of stigma; recognize stigma as a central component in all mental health-related problems	Copernicus Project: a train-the-trainer package or in-person workshops utilizing case studies, games, problem-solving frameworks, and debates; both formats are identical in content and duration	“Copernican Shifts”: 4 2-hour workshops; “What’s up With Biff?”: 1-hour stand-alone workshop	Corporate community (not otherwise specified)
Canadian Mental Health Association Ontario (38)	Canada	Not specified	Improve the health of individuals and organizations; specifically address stigma and discrimination	Workplace Mental Health Promotion: provides fact sheets, definitions of stigma, and consequences of stigma	Ongoing; materials accessed via Web site	Employers, employees
Dowling et al. (32)	United States	Police department	Address issue of unwillingness to share problems with mental health professionals; decrease fears of stigmatization	Police Organization Providing Peer Assistance: uses trained volunteer officers as peer support; 24-hour help line	Ongoing; 24-hour help line	New York Police Department; New York City and surrounding counties
Great-West Life (34)	Canada	Not specified	Raise awareness and reduce stigma in the workplace	Centre for Mental Health in the Workplace: strategies, tools, and support for research and initiatives	Ongoing; materials accessed via Web site	Supervisors, employees, union leaders, senior leaders, human resources professionals, occupational health professionals, disability management professionals

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Author or sponsor organization	Country	Workplace setting or industry	Specific antistigma goals ^a	Type of stigma intervention	Duration or frequency of intervention	Study or target population
Greden et al. (28)	United States	Military: National Guard and Reserves	Counteract stigma and other barriers; create pathways to get and keep soldiers in treatment; create pathways for families to obtain support	Buddy-to-Buddy: peer-to-peer strategies	“Regular” check-in calls (not otherwise specified)	Citizen soldiers
Grenier et al. (29)	Canada	Military	Reduce stigma, shame, and isolation endured by persons with PTSD	Operational Stress Injury Social Support Program: a peer-support model and speakers bureau	Ongoing use of peer-support coordinators and a speakers bureau	Soldiers
Gould et al. (31)	United Kingdom	Military	Modify attitudes about PTSD, stress, and help seeking; train nonclinical, active service members to identify at-risk individuals for early intervention	Trauma Risk Management Program: a psychoeducational management strategy; didactic teaching and role play	2.5 days	Service members of the U.K. armed forces
Kitchener and Jorm (26)	Australia	Large government departments	Teach skills in giving initial help and support to someone experiencing a mental health problem; teach how to take action if a crisis situation arises	Mental Health First Aid: training; set lesson plans	3 weekly sessions of 3 hours each	Employees of 2 Australian government departments
Knifton et al. (27) ^b	United Kingdom	Benefits, housing, employment, voluntary-sector agencies	Promote positive attitudes, challenge negative stereotypes, and create positive behavioral intent among targeted audiences	Service user narratives, experiential group learning, didactic teaching approaches	6-hour workshop divided into 7 sections	Employees of workplaces of importance to people who experience mental health problems
Lunasco et al. (30)	United States	Military	Reduce stigma and improve help-seeking behaviors among the “warrior culture”	One Shot–One Kill: 5 educational modules, including stress management and enhancing purpose and meaning	2-day, 4-hour training program	Military service members
Mental Health Works (43)	Canada	Not specified	Reduce discomfort in talking about mental illness, reduce fear of coworkers who are ill, increase ability to respond supportively	Awareness of Mental Health in the Workplace: presentations with video of people with mental health issues	1-hour condensed presentation; 3-hour presentation recommended	Employees

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Table 1

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Author or sponsor organization	Country	Workplace setting or industry	Specific antistigma goals ^a	Type of stigma intervention	Duration or frequency of intervention	Study or target population
Mood Disorders Association of Ontario (35)	Canada	Workplaces in public and private sectors	Reduce fear and misconceptions of mental illness; decrease reluctance to talk about it; create more effective conversations	Mental Health in the Workplace: Shifting Perceptions: stories, facts, interactive problem solving; group work with case scenarios	Half-day session	Managers, employees, employers
Munday (25)	United Kingdom	Health care	Reduce stigma and misunderstanding about mental illness	Open Your Mind: online toolkit for National Health Service organizations, support materials, case studies, and videos	Open-access Web site with tools	Workers in the National Health Service
Orsingher et al. (23)	United States	Military	Eliminate stigma that surrounds the search for behavioral health care	Battlemind Training System: peer intervention techniques, training and education, train-the-trainer, Web site containing interactive videos, marketing	Variety of programs within each of 3 distinct cycles of military life; range from 1 hour (not otherwise specified)	Senior leaders and officers, enlisted and officer personnel, families
Queensland Alliance for Mental Health (39)	Australia	Employers and Disability Employment Network providers	Address many misconceptions and stigmatizing attitudes and beliefs about mental health issues	Mental Health Works: DVD and online videos, interactive PDF, online resources	Ongoing: open-access Web site with interactive PDF, videos, resources	Employees, employers
Quinn et al. (24) ^b	United Kingdom	Housing association and telecommunications workers	Promote positive attitudes and challenge negative stereotypes; create positive behavioral intent among targeted audiences	Service user narratives, experiential group learning, and didactic teaching approaches	9 1-day training courses	Employees
SANE Australia (40)	Australia	Not specified	Reduce misunderstanding and unhelpful attitudes toward mental illness in the workplace	Mindful Employer: 10 core components, including podcasts, fact sheets, helpline, Web site	Ongoing: open-access Web site with tools, resources, contact information	Employers, employees
See Me (41)	Scotland	Not specified	Increase local antistigma activity by providing easy-to-use tools	Stigma in the Workplace: toolkits, resources, PowerPoint presentations, case studies, planning tools, legal implications, “what employers can do”	Ongoing: open-access Web site with tools and resources	Not specified

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Author or sponsor organization	Country	Workplace setting or industry	Specific antistigma goals ^a	Type of stigma intervention	Duration or frequency of intervention	Study or target population
Shaw Trust (37)	United Kingdom	Not specified	Provide strategies to deal with stigma; help managers to support staff dealing with mental health issues	Ability at Work: Tackling the Last Workplace Taboo: checklists, suggestions, "dos" and "don'ts"	Ongoing; open-access site with resources	Not specified
SHiFT (42)	United Kingdom	Not specified	Support managers and employers to promote good mental health and reduce stigma and discrimination	Shifting Attitudes to Mental Illness: printable handbook with links to other organizations and Web sites; learning tools; video clips	Ongoing; open-access site with resources	Line managers and others in public- and private-sector organizations
SAMHSA ^c (36)	United States	Not specified	Reduce stigma and discrimination associated with mental illnesses	Businesses Materials for a Mental Health Friendly Workplace: booklet start-up package	Ongoing; open-access site with resources	Human resources personnel, management

^a PTSD, posttraumatic stress disorder^b Knifton et al. (27) and Quinn et al. (24) appear to have used the same intervention; however, both studies provided distinctly different perspectives. Only one account of the intervention was utilized for comparison purposes.^c SAMHSA, Substance Abuse and Mental Health Services Administration

effects were reported by only one Internet initiative (33). These changes included increased utilization of related services, improvement in measures of social distance, and confidence in providing help to others. Despite the report of positive outcomes in these six interventions, the overall evidence for their effectiveness was mixed. There was a lack of clarity as to which specific component of the intervention was most effective in reducing stigma. The interventions that utilized an educational approach reported an improvement in knowledge and attitudes toward mental illness regardless of format (such as workshops, psychoeducation, lesson plans, and modules).

Statistically significant findings regarding stigma reduction were reported in each of the four research-based articles included in this scoping study. Such findings included an improvement in help-seeking behavior and in attitudes toward stress (31); an improvement in overall attitudes, including the means of all items for recovery, dangerousness, and unpredictability (27); changes in participant beliefs about treatment for both schizophrenia and depression, in participants' attitudes about social distance from persons with depression, and in participant's confidence in providing help to others (26); and changes in reducing the level of stigmatizing attitudes in both first-person views ("Do you personally think that . . . ?") and third-person views ("Do other people think that . . . ?") (24). These four articles (24,26,27,31) reported overall positive effects on knowledge and, for the most part, on general attitude toward individuals living with mental illness. However, some deeply engrained stigmatizing beliefs and behaviors remained resistant to change.

Discussion

Although workplace antistigma interventions are limited in number, those described in the literature and on the Internet share principles and characteristics. Most emphasize an educational approach to reducing stigmatizing attitudes toward and beliefs about mental illness. This finding corresponds with research that indicates greater use

of educational approaches than of personal contact with individuals living with mental illness, regardless of evidence that personal contact has proven to be more effective with adults (13). The absence of personal contact in intervention strategies may be explained in part by the logistical challenges of involving people with mental illness in antistigma initiatives. It may be considered resource intensive and costly to locate, train, support, retain, and compensate individuals with mental illness so that they can be regularly involved in intervention strategies.

Most of the initiatives reviewed here have appeared within the past four years and across geographic boundaries, reflecting the growing international interest in mental health in the workplace. The emergence of initiatives also coincides with a global increase in the promotion of mental health and the development of public health policy, legislation, and regulatory reform. All of the reviewed workplace antistigma interventions were from English-speaking liberal democracies, specifically from Australia, Canada, the United Kingdom, and the United States. This policy context sets the tone for attitudes and beliefs about inclusion of persons with mental illness in mainstream society and work, about the rights of those in the workforce, and about the responsibility of organizations and society at large.

This study also revealed a large proportion of antistigma initiatives that target armed forces and law enforcement personnel. The military has been aggressive in addressing mental health issues that are commonly experienced by service personnel, such as posttraumatic stress disorder. These leading initiatives convey the importance of developing tailored workplace or occupation-specific antistigma interventions. Research has indicated that the type of stigma experienced by individuals may also be dependent on particular diagnoses and the presentation or severity of symptoms. For example, Griffiths and colleagues (45) reported greater social distance, greater personal stigma, and greater perceived stigma toward individuals with

schizophrenia than toward those with depression. Furthermore, the findings of Crisp and colleagues (46) indicate that individuals with severe depression are perceived as difficult to talk to and dangerous to others. Because mental health issues can also be manifested or expressed differently depending on the context of the workplace, occupation, or culture, it is imperative to identify workplace-specific factors that will inform the design and delivery of targeted antistigma strategies.

This scoping study had some limitations that are important to note. Information gathered from the Internet was reported solely on the basis of what was available from the accessed Web site; some of the interventions may have had formal outcome measures or research designs that were not accessible from the Web site. In addition, the scoping study did not include workplace interventions designed to increase literacy in mental health, improve self-management or self-care, or improve overall wellness. These interventions were excluded because stigma reduction was not a primary and explicit goal, but it is entirely possible that these interventions do normalize the experience of mental illness and decrease stigma toward it.

Conclusions

Workplace antistigma initiatives have increased in recent years; however, few conclusions can be drawn about their effectiveness. Reasons include a small number of studies, a lack of use of evaluation tools with established psychometric properties, and a lack of long-term follow-up evaluation efforts and data. Evaluation initiatives are currently under way in Canada (47) and will provide the field with direction on critical ingredients of such programs. Interventions need to address the multifaceted nature of stigma and consider the diverse needs of various stakeholders in the workplace setting. Continued research in this area is needed to elucidate the effectiveness and quality of workplace interventions in order to determine the degree to which interventions should be modified for diverse occupations. Stronger evidence can be established through the use of stan-

dardized workplace-specific interventions, reliable and valid evaluation tools, and overall enhanced scientific rigor.

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