BMJ Open

Worker and manager perceptions of a proposed community-based approach to work-related mental injury prevention: a qualitative study based on the theory of planned behaviour

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2021-056472
Article Type:	Original research
Date Submitted by the Author:	17-Aug-2021
Complete List of Authors:	Crisan, Corina; Monash University, Monash Sustainable Development Institute Van Dijk, Pieter; Monash University, Monash Business School Oxley, Jennie; Monash University, Monash University Accident Research Centre De Silva, Andrea; Monash University, School of Public Health and Preventive Medicine
Keywords:	MENTAL HEALTH, Health policy < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Health & safety < HEALTH SERVICES ADMINISTRATION & MANAGEMENT

I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our licence.

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which Creative Commons licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

TITLE

Worker and manager perceptions of a proposed community-based approach to work-related mental injury prevention: a qualitative study based on the theory of planned behaviour

1 Corina Crisan

2 Pieter Andrew Van Dijk

3 Jennie Oxley

4 Andrea De Silva

Corresponding author

Correspondence to Corina Crisan, email: corina.crisan@monash.edu, mobile: +61 466688138

Word count:

4,243

Keywords

mental injury, workers, managers, help-seeking, mental health literacy, community-based approach, community organisations, Theory of Planned Behaviour, underlying beliefs

ABSTRACT

Objectives

Reluctance to seek help is a leading contributor to escalating mental injury rates in Australian workplaces. We explored the benefit of using community organisations to deliver mental health literacy programs to overcome workplace barriers to help-seeking behaviours.

Design

This study used a qualitative application of The Theory of Planned Behaviour to examine underlying beliefs that may influence worker's intentions to participate in mental health literacy programs delivered by community organisations, and manager support for them.

Setting

This study took place within three large white-collar organisations in the Australian state of Victoria.

Participants

Eighteen workers and eleven managers (n=29) were interviewed to explore perspectives of the benefits of a community-based approach.

Results

Community organisations have six attributes that make them suitable as an alternative mental health literacy program provider including empathy, safety, relatability, trustworthiness, social support, and inclusivity. Behavioural beliefs included accessibility, understanding, and objectivity. The lack of suitability and legitimacy due to poor governance and leadership were disadvantages. Normative beliefs were that family and friends would most likely approve, while line managers and colleagues were viewed as most likely to disapprove. Control beliefs indicated that endorsements from relevant bodies were facilitators of participation. Distance/time constraints, and the lack of skills, training and lived experiences of coordinators/facilitators were seen as barriers.

Conclusions

Identifying workers' beliefs and perceptions of community organisations has significant implication for the development of an effective community-based approach to improve worker mental health literacy, and help-seeking. Organisations with formal governance structures, and allied with government, peak bodies and work-related mental health organisations would be most suitable. Programs should focus on lived experience and be delivered by qualified facilitators. Promoting supervisor and colleague support could improve participation. Models to guide cross-sector collaborations to equip community organisations to deliver work-related mental health literacy programs need to be explored.

ARTICLE SUMMARY

Strengths and limitations of this study

- This is the first study that used a qualitative framework to explore worker and manager perceptions of the benefit of using community organisations to deliver mental health literacy programs to help prevent work-related mental injury.
- Understanding the underlying beliefs influencing workers' participation in community-based mental health literacy programs using a psychological theory-based decision-making model (Theory of Planned Behaviour), is critical for the development of effective strategies to improve engagement rates.
- Mental health literacy programs delivered by community organisations could help overcome some of the barriers to seeking help associated with the workplace such as fear of discrimination and unsupportive work cultures.
- The small sample size may limit the transferability of findings.
- White-collar workers from large organisations located in a metropolitan area may have different beliefs than those from blue-collar, smaller organisations or located in remote or regional settings.

INTRODUCTION

Reluctance to seek help is a leading contributor for escalating mental injury rates in Australian workplaces[1–3]. The financial cost of work-related mental injuries to Australian workplaces is significant, estimated to be more than $12 billion per year in lost productivity[4]. Work-related mental injuries are associated with work-related factors such as job demand and pressure, harassment, bullying, exposure to violence or traumatic events, and interpersonal conflict[5–7]. Many workers are reluctant to use the mental health programs and support mechanisms provided by their workplace[8,9]. Attitudinal barriers to help-seeking include stigma, unrecognized need for help, preference for self-reliance, and belief that treatment would be ineffective[10,11]. Workplace barriers include mistrust of embedded programs such as Employee Assistant Programs, fear of discrimination or repercussion on their career, limited confidence in managers' capabilities surrounding disclosure, and unsupportive organisational cultural norms[12–15]. Furthermore, structural barriers such as the unavailability of service providers outside working hours can also affect access to care[11].

The escalating work-related mental injury rates[4] warrant exploration of alternative ways to reach workers who may be unwilling, or unable, to access organisational and public health support before their mental health concerns reach unhealthy levels. Currently under-explored is the utility of community organisations (COs) to deliver work-related mental health literacy programs designed to address barriers to help-seeking behaviours. These organisations are non-governmental, not-for-profit, that operate for social purposes[16], are accessible and trusted sources of support, and have reach into many sections of the community[17]. Such an approach could conceivably be more appealing and effective than organisational initiatives.

Mental health literacy refers to knowledge about mental illness and the skills required to recognise, manage, and/or prevent it[18]. The lack of mental health literacy is a key barrier to help-seeking of workers[19,20]. Building workers' capacity/capability to recognise the symptoms of mental ill-health is critical for addressing work-related mental health problems[11,21,22]. Recognising this, many workplaces have implemented mental health literacy programs[19,23,24] and use these initiatives to promote pathways and referrals to professional services offered in the workplace or by public health practitioners[25]. Though these efforts have increased literacy levels of workers[22,26], evidence suggests this has not resulted in supportive attitudes or behaviours in the workplace[27] and therefore low disclosure rates in workplaces are still a problem in addressing work-related mental injuries[9,28].

Previous studies have demonstrated that supportive social referents can be beneficial in the help-seeking process[8,29]. An encouraging environment will facilitate workers' confidence, and the development of tools required to seek timely access to mental health treatment[27]. A supportive workplace management culture exhibiting positive attitudes toward mental health can facilitate workers' willingness to disclose mental health problems[30]. Evidence suggests however that support in many workplaces is insufficient to overcome worker reluctance to seek help. For example, a study has shown that perceptions of bias, role conflict, and hierarchical relationships between the help provider and recipient significantly impact disclosure rates[31]. Importantly, a perceived lack of genuine care and support can contribute to a worker's exclusion, leaving them feeling isolated[27,32,33]. The limitations of current approaches point to the need to explore solutions that can provide the level of support required to encourage workers' help-seeking behaviours.

Such an opportunity may exist in adopting a more socially inclusive approach at a community level[34,35]. COs, such as sporting clubs, men's sheds and neighbourhood houses, currently provide support for people within the community for a broad range of mental health problems through literacy training and guest speaker events that are designed to destigmatise mental illness and encourage help-seeking, but do not directly address work-related mental health and worker-specific needs[17,36,37]. A strength of a community-based approach is the practical advice provided by peers with lived experience with no perceived inequality in the power relationship. This has been found to significantly improve participants' recognition of emotional problems, confidence, and coping skills[38–40]. In the context of work-related mental injury, this could involve providing work-focused programs tailored to worker needs delivered outside of workplace settings. As COs have a large reach and are an integral part of the Australian social fabric, they are well-placed to be a vehicle to reach disadvantaged and isolated workers by providing tailored opportunities to access mental health literacy programs to overcome barriers to help-seeking[41]. What needs to be determined is if such an approach has any appeal or perceived benefit.

Theory of Planned Behaviour

To address the identified gaps in the literature, this study applied the Theory of Planned Behaviour (TPB), a theory-based and robust decision-making model that is the most applied framework to better understand decision-making and behaviour change[42–46]. The TPB posits that intention to perform a behaviour is primarily guided by three constructs. These are attitude (overall evaluation of participation), subjective norms (perceived social pressure associated with participation), and perceived behavioural control (the perceived degree of ease or difficulty to participate). Each of these constructs are influenced by the associated underlying beliefs, including behavioural beliefs (advantages and disadvantages of participation), normative beliefs (key referents who approve or disapprove of such participation), and control beliefs (barriers or facilitators to participation). The TPB is used in this study as an evidence-based framework for examining key beliefs influencing worker attitudes and intentions toward making use of the proposed CO-delivery of mental health literacy programs. A key strength of the TPB is that it facilitates identification of beliefs that differentiate users and non-users[47], which can help in the development of targeted strategies to facilitate decision making/behaviour change[45].

The Current Study

The objective of this study is to determine the potential utility of a community-based approach to overcome workplace barriers to help-seeking behaviours. The two aims associated with this objective are (1) to explore attributes of COs that make them suitable to deliver work-related mental health literacy programs from the perspective of workers (as a potential user) and managers (as an important social referent), and (2) to examine the motivations that influence worker intentions to potentially participate in such programs, including how prior or current associations with COs may influence these motivations.

To the authors' knowledge, no previous studies have used the TPB to explore the factors influencing workers' potential participation in CO-delivered mental health literacy programs, or to explore perceptions of a key social referent group (managers) toward such an approach. It is anticipated that the results of this study will inform opportunities for cross-sector collaborations to promote and enhance worker participation in community-based activities for the prevention of work-related mental injury.

METHODS

Guidelines developed by O'Brien, Harris, Beckman et al (2014) were followed to ensure the transparency of reporting on research design and methods of data collection and analysis[48].

Procedure

CEOs or HR/OHS Managers from twenty-seven large organisations (with 200+ workers) in the Australian state of Victoria with comprehensive mental health programs in place were contacted by email with an invitation to participate in the study. The information included that the purpose of the interviews was to explore perceptions of workers and managers within the organisation about the potential utility of a community-based approach to address barriers to help-seeking for work-related mental injury. The invitation established that no mental health assessment would be conducted, participation was anonymous, voluntary, and information collected would be confidential. No reimbursements were provided. Out of twenty-seven organisations, nine initially responded (33%) however only three workplaces finally participated (11%) due to challenges related to COVID-19. The information flyer and consent form were distributed through formal organisational communication channels, as approved by the Monash University Human Research Ethics Committee (project ID: 20548). Selection criteria for workers included any full or part-time staff in a permanent or contracted role and who had been employed with the organisation for at least 6 months. Managers were invited based on their level of seniority within the organisation (executive or senior managers) and/or expertise in HR/OHS (convenience sample). The first author contacted respondents who expressed interest to confirm their eligibility. Informed consent was obtained from all participants prior to data collection.

The interviews were conducted via video platforms (Zoom/Microsoft Teams) due to COVID-19 physical distancing restrictions at the time of data collection[49]. The purpose of the research was explained, and demographic information was collected. Participants were informed that they could withdraw from the study at any time. Established interview protocols and techniques were followed to minimise interviewer and response bias[50]. Twenty-nine interviews were conducted over a four-month period between January and April 2020. Interviews were audio-recorded (average duration 46 minutes). Field notes were made following each interview to document the interviewer's impressions and ensure reflexivity[50]. Data collection ceased at the point of data saturation[51]. The transcriptions were stored on a password-protected computer to which only the first two authors had access.

Materials

In addition to general questions exploring managers' and workers' views of, and workers' prior or current associations with COs, a belief elicitation interview protocol was used to explore workers' underlying beliefs about using mental health literacy programs delivered by COs (see supplemental material A). Interviews included open-ended questions and a conversational style to allow in-depth examination of participants' perceptions and experiences[50]. To explore underlying behavioural beliefs, workers were asked about advantages and disadvantages of attending these programs if the need arose. Normative beliefs were identified through questions about the role of significant people within their social and work networks in their decision to participate in these programs. Control beliefs were explored through questions focusing on what made it easier or more difficult for workers to participate, and what encouraged or prevented them from using such

opportunities. Probing questions were used when needed to clarify the responses, gain further insights, and overcome researcher bias[48]. Managers with HR/OHS experience were interviewed to understand how community-based approaches might be perceived and supported in workplaces. Particularly, to understand whether they believed such approaches would complement existing workplace-based programs, and/or overcome some of the perceived access barriers associated with these programs (see supplemental material B). The interview protocols were piloted with three workers and two managers from the research team's professional network and subsequently refined prior to commencing data collection. This data was excluded from the analysis.

Participants

Participants (n=29; 16 female, 13 male) of which eighteen workers and eleven managers were aged 29–64 years. Eighteen participants worked in the public sector and eleven in the private sector. Nineteen participants were employed in an ongoing role, with the remainder in a contracting role. Participants were also classified as 'With Associations' (A) or 'Without Associations' (WA) depending on whether they had prior or current associations with COs or not. Table 1 shows the key demographic details of participants.

Table 1 *Demographic Characteristics of Study Participants*

		Workers; n (%)	Managers; n (%)
Associations with COs	With associations (prior/current)	9 (50%)	5 (45.5%)
	Without associations	9 (50%)	6 (54.5%)
Gender	Female	11 (61.1%)	5 (45.5%)
	Male	7 (38.9%)	6 (54.5%)
Age	25-34	1 (5.6%)	0 (0%)
	35-44	5 (27.8%)	5 (45.5%)
	45-54	6 (33.3%)	3 (27.2%)
	55-64	6 (33.3%)	3 (27.2%)
Employment Tenure	Permanent	13 (72.2%)	6 (54.5%)
	Contracted	5 (27.8%)	5 (45.5%)
Industry	Public sector	12 (66.6%)	6 (54.5%)
	Private sector	6 (33.4%)	5 (45.5%)

Patient and Public Involvement

This study involved no patients, only members of the public who were in active employment. No assessment was made on their current or past mental health state. In accordance with the ethics approval, each participant was provided with an information sheet containing the research team's contact details.

Data Analysis

All interview responses were transcribed verbatim by the first author, which were then confirmed for accuracy by the second author and imported into NVivo 12 software[52]. Each interview transcript was deidentified and assigned a unique code (W-worker, M-manager). Braun & Clarke's six stage thematic approach (familiarisation with the data, coding, searching for themes from the codes, reviewing themes, defining and naming themes,

and writing up the themes)[53] was used to identify and interpret patterns within data. Data analysis was both inductively and deductively compared to the TPB framework[54].

The first author coded responses of a subset of interview transcripts (n=5) using the TPB framework and constructs (behavioural beliefs, normative beliefs, and control beliefs). Field notes that were written following each interview were subsequently used in data analysis discussions among research team members to overcome any potential biases[50]. The initial codes were checked for emerging patterns and grouped into a draft framework of themes that were semantically close to the participants' wording[55]. Where applicable, themes were further split into sub-themes. The validity of these themes and sub-themes was checked by the second and third authors who have expertise in qualitative methods. It was determined that they were relevant to the research questions and representative of the data[53]. The framework was then applied to the remaining transcripts, whilst allowing for emergent themes until no new themes could be determined[56].

As the fieldwork and data analysis progressed, transcripts were reviewed systematically by the team's qualitative experts, and themes were refined iteratively based on recurrence and their relationship to each other. Any differences of opinion were discussed until consensus was reached among the research team. Once themes and sub-themes were confirmed, data was explored to identify common themes and understand the relationship between them[53]. Inter-rater reliability reached 90 per cent agreement[56].

RESULTS

Table 2 summarises workers' and managers' views about the attributes of COs that make them suitable for providing work-related mental health literacy programs with supporting quotes. Empathy, safety, relatability, trustworthiness, social support, and inclusivity were reported as appealing attributes of COs. Table 3 summarises the findings by the TPB belief categories. These are further divided by workers with associations with COs and those without, with supporting quotes. For the behavioural beliefs, the most reported advantages of participation in programs delivered by COs included accessibility (acceptability and approachability), understanding (hearing peers' lived experiences of work-related mental injury and sharing of lived experience with peers), and objectivity (unbiased by organisational goals and independent from workplaces). None of the workers without associations reported sharing of lived experience with peers, and independent from workplaces as advantages. The lack of legitimacy (leadership and governance), and lack of suitability were reported as disadvantages. No worker without associations mentioned issues surrounding leadership. For the normative beliefs, family and friends were reported as the social referents most likely to approve, while line managers and co-workers were viewed as most likely to disapprove of such participation. For the control beliefs, third-party endorsement was the most reported facilitator. Affiliations with peak organisations, or those with work-related mental health expertise were reported by workers with prior or current associations with COs. Those without associations reported endorsement by government bodies. Limited access (distance and time constraints), and the lack of skills, training and lived experiences of coordinators/facilitators (unqualified, celebrity) were the commonly reported barriers.

Table 2 *Attributes of Community Organisations*

Themes	Sub-themes	Workers n= 18	Managers n = 11	Representative Quotes
Empathy (n=13)	Person-centred (n=8)	4	4	Community organisations are so good at looking after the person and delivering a person centric service. (M4, WA*)
	Caring (n=5)	4	1	Those people, especially if they are members of community groups like CWA, are more empathetic. Those group members are there to be part of a social group and to participate in society. They are not fly fishing by themselves or looking for some rich boys' club reasons to participate. (W4, A**)
Safety (n=12)	Outside of workplace setting (n=6)	3	3	One of the things that would be appealing to seek community-based support for mental health issues is that it's separate from your workplace. You can have a conversation with someone who's trusted in that space, without wondering if your boss is telling someone else, which just creates anxiety. (M3, A)
	Confidential (n-5)	2	3	It's about having that confidence that what's said in the room stays in the room. (W1, WA)
	Positive (n=1)	1	0	Something like a men's shed that has a really positive kind of vibe, a positive atmosphere and it's safe, that would be good. (W17, A)
Relatability (n=12)	Non-clinical and less stigmatising setting (n=8)	4	4	I think these organisations could help make mental health something that people talked about more freely because they've got less stigma about it, so you don't feel like there's something wrong with you as when you go to a professional. (W10, WA)
	Including people to which participants could relate (n=4)	3	1	Having an organisation with people that actually have lived experience that can be advocates of reaching out to people with similar issues, who can actually explain 'this is how I went through it', it's important. (W13, WA)
Trustworthiness (n=11)	Unbiased by organisational goals (n=6)	2	4	Having someone who's not biased, who is not invested either way, who can sit back, and listen in a way that's not judgmental, getting them to tell their story, to open up. I think in the workplace it's difficult to achieve that. (M6, WA)
	Independent from workplaces (n=5)	3	2	They are independent, and that's what makes their message so powerful. It goes back to trust and that's where the community organisations fit in. (W17, A)
Social support (n=9)	Social connection (n=5)	4	1	If you really struggle with work, or is something awful going on there, you know that you've got another thing that supports you. (W9, A)
	Sharing experiences (n=3)	3	0	You can share your problems and get some support. (W4, A)
	Companionship (n=1)	0	1	They provide a place to talk and offer companionship. (M6, WA)
Inclusivity (n=9)	Value-based (n=4)	3	1	A community organisation that is open to diversity would make it much easier for people to engage, it's good to have that ability to talk to someone that completely understands from where I'm coming from and what are the taboos in my culture. (W8, A)
	Interest-based (n=3)	2	1	They provide opportunity to share my passions and interests, because then I could feel that I'm with like-minded people and I'm doing something I love so I can forget about everything else what's going on in my life. (W10, WA)
	Overcome isolation (n=2)	1	1	They make sure people are included, that they are not isolated. (M6, WA)

* WA – without associations with COs, ** A – with associations with COs

W - worker, M - manager

Table 3 *Summary of Workers' Underlying Beliefs*

Themes	Subthemes	Workers with associations (A)	Workers without associations (WA)	Representative quotes
BEHAVIOURAL BELIEFS				
Advantages				
Accessibility (n=13)	Acceptability (n=7)	4	3	There is that kind of feeling that if I walked within a community organisation and something happened to me, that I'd be looked after. (W4, A).
	Approachability (n=6)	2	4	It's like talking with a friend, while when I seek professional assistance, that would be clinical, sterile, impersonal and probably an isolating experience. (W8, A)
Understanding (n=8)	Hearing peers' lived experiences of work-related mental injury (5)	3	2	It's about the people who have been through challenges providing advice to others that puts things in perspective, that makes it really special. (W1, WA)
	Sharing of lived experience with peers (n=3)	3	0	I think they are supportive for your mental health, because you can share your problems and get some support. And in that way you don't feel like you're alone with your problem. (W4, A)
Objectivity (n=5)	Unbiased advice (n=3)	2	1	They are neutral, so because of that I would respond well to them. (W17, A)
	An independent perspective (n=2)	2	0	Being external, they are independent from the workplace and therefore more supportive for your mental health. So you can have a conversation with someone who's trusted in that space without wondering if your boss is telling someone else that just creates anxiety. (W4, A)
Disadvantages				
Lack of legitimacy (n=7)	Issues surrounding leadership (n=4)	4	0	If the person behind the organisation is not trusted, if there are problems with the organisation, then people won't trust them. (W7, A)
	Concerns regarding governance (n=3)	2	1	It's making sure that the organisation doesn't come with too much baggage, that there are proper checks in place. (W17, A)
Lack of suitability (n=6)		2	4	There would be a little bit of an education piece on why they were doing it, because my first thought would be to think of Beyond Blue or ones that specialise in mental health. (W17, A)
NORMATIVE BELIEFS				
Approve				
Family (n=7)		4	3	My family, they supported me a few years ago when I needed some time off work. (W2, WA)
Friends (n=5)		4	1	I have a network of trusted, old friends that would be supportive. (W4, A)
Disapprove				
Line manager (n=6)		1	5	When I'm expressing to my boss that I'm stressed and give him cues about my mental health and invite him to have a conversation with me so that we could actually work out what we could do together to make the situation more manageable, he absolutely ignored my cues. So I'm not going to talk to him about my anxiety levels and about seeking help because I know it will fall on deaf ears. (W5, WA)
Work colleagues (n=5)		1	4	I wouldn't talk about this in the workplace with my colleagues because I know that is a career limiting move. (W15, WA)
CONTROL BELIEFS				
Facilitators				
Third-party endorsement (n=7)	Recommendations from government bodies (n=3)	0	3	A neutral, objective agency could be useful as an intermediary to vouch for them. I think some community service announcement from government would be a good way to do this. (W3, WA)
	Recommendations from appropriately qualified organisations (n=2)	2	0	Organisations that employ practitioners are better fitted to provide specialist support or link to community groups that provide mental health information and advice. (W9. A)
	Affiliations with peak bodies (n=2)	2	0	Something like Neighbourhood Houses or CWA have the established credentials to be able to sort of support and validate that a little bit. (W4, A)
Barriers				
Limited access (n=10)	Time limitations (n=6)	4	2	It's great to have all the community support available but if you don't really have the time in your life to actually make that effort…people in our industry don't have this option. (W13, WA)
	Distance constraints (n=4)	2	2	There're still challenges related to geographical distance. Maybe there is a good thing that comes out during this COVID-19 is to normalise video participation in wellbeing activities. (W5, WA).
Lack of skills, training and lived experiences of coordinators/facilitators (n=5)	Unqualified (n=3)	1	2	It's become more obvious with COVID-19 that people are really not supportive of speakers that give statements and health advice without proper credentials. Because they could actually do worse for people. (W4, A)
	Not attracted to celebrity (n=2)	0	2	Celebrity status of a speaker is not a drawing card for me. If you're coming in as if you're a powerhouse, you'll lose your audience. (W1, WA)

WA – without associations with COs, A – with associations with COs, W - worker, M - manager

DISCUSSION

The aims of the current study were to explore the potential benefit of COs to deliver work-related mental health literacy programs from worker and manager perspectives, and to identify worker motivations that might influence intentions to participate in such programs[45,57]. Overall, managers and workers believed that COs had the potential to be a viable, and appealing, alternative to workplace-based programs. Prior or current associations with COs had an impact on workers' perceptions of the advantages and challenges of such an approach. First, findings are discussed in relation to the features of COs as suitable providers of programs, followed by each of the TPB underlying belief categories of workers (behavioural, normative, and control).

Attributes of Community Organisations

Workers and managers believed that using COs to provide mental health literacy programs could potentially overcome some of the barriers to accessing mental health support within workplaces. **Empathy** (n=13) was the most reported attribute which entailed two sub-themes being person-centred (n=8), and caring (n=5). Personalised affective responses to individuals' experiences, feelings and situations[58] have been shown to increase their willingness to seek help[59]. Next was **safety** (n=12) in terms of being outside of workplace setting (n=6), confidential (n=5), and positive (n=1), which could help to overcome some workplace barriers such as fear of discrimination or repercussion on career[12,15]. **Relatability** (n=12) was reported next. This referred to COs being a non-clinical and less stigmatising setting (n=8) and including people to which participants could relate (n=4). This implies COs provide psychologically safe, judgement free, and less intimidating environments that could facilitate worker engagement and help-seeking[60]. **Trustworthiness** (n=11) was the fourth attribute reported as COs are independent from workplaces (n=5) and are unbiased by organisational goals (n=6). This feature may overcome concerns about discrimination and marginalisation associated with help-seeking at work[12,15,24], and supports prior research findings relating to COs' position of trust in the community[17]. **Social support** (n=9), reflected in social connection (n=5), sharing experiences (n=3), and companionship (n=1), and **inclusivity** (n=9)**,** divided into value-based (n=4), interest-based (n=3), and overcoming isolation (n=2), were reported as positive attributes of COs. These results suggests that workers and managers perceive that COs possess a range of attributes that position them favourably to support community efforts to improve the mental health literacy of workers. Next, we explore the underlying motivations of workers to use such opportunities.

The Theory of Planned Behaviour

Behavioural Beliefs

Accessibility to programs is seen as a key advantage by both worker categories (n=13). This supports prior research findings into the role of community-centred approaches in improving access and use of health-related services[61]. Two sub-themes, consistent with Levesque's dimensions of service accessibility[62], were acceptability (n=7) and approachability (n=6). Acceptability is the extent to which workers considered programs delivered by COs to be appropriate to their needs[63]**.** Approachability indicates that workers identified that such a service can be reached and could have a positive impact on their mental health literacy[62]. These two dimensions are critical success factors for initiatives designed to provide health-related services such as work-related mental health literacy programs[62,64,65].

The next advantage of the proposed programs reported was **understanding** (n=8). Understanding had 2 sub-themes which were hearing peers' lived experiences of work-related mental injury (5) and sharing of lived experiences with peers (n=3). Hearing the experiences of peers and being able to share experiences with them serves to provide hope[66,67], alleviate stress and uncertainty[68], de-stigmatise mental injury[69], reduce fear and feelings of isolation[70], and is an important step in encouraging disclosure and help-seeking[71]. None of the workers without previous or current associations reported the sharing of lived experience as an advantage. This suggests that they are not familiar with some of the peer-to-peer benefits of COs and by extension programs offered by them. Strategies emphasising the benefits of engaging with peers that have similar experiences through these programs may improve workers' awareness, and motivation to participate.

The third advantage reported was **objectivity** (n=5), understood in terms of unbiased advice (n=3), and an independent perspective (n=2). Unbiased and independent advice and information serves to alleviate some of the barriers associated with workplace-based programs and contexts, such as concerns about fear, stigmatisation, judgement, and privacy that have been linked to worker reluctance to use workplace counselling services[72–75]. None of the workers without associations with COs identified an independent perspective as an advantage. Communication promoting this, as well as the unbiased nature of community-based programs may enhance participation.

The **lack of legitimacy** (n=7) was the most reported disadvantage. This theme included leadership (n=4), and governance (n=3). Most workers that indicated these concerns had previous or current associations with COs which may reflect some challenges associated with organisations that rely heavily on untrained volunteerism. Screening for organisations that are appropriately structured, led, and governed to deliver these programs is important as worker choices to participate may depend on the perceived quality of leadership and governance of COs. The **lack of suitability** (n=6) was another disadvantage. COs are highly diverse regarding reputation, mission, size, resources[17] and therefore, only organisations that are appropriately positioned should be selected to provide these programs.

Normative Beliefs

Family (n=7) and **friends** (n=5) were reported as the social referents (important others) most likely to approve participation in programs offered by COs for both categories of workers. In contrast, **line managers** (n=6) and **co-workers** (n=5) were believed to likely disapprove, particularly by workers without associations (n=9). Research has shown that organisational culture and social norms strongly impact workers' disclosure and help-seeking behaviours[28,29,76–78]. This suggests that for workers without associations, direct managers continue to be important social referents while workers with prior or current associations were less influenced by the opinions of those within their workplace. Associations with COs present a strong social network which may weaken the reliance on the approval of workplace referents when considering help-seeking which strengthens their potential in delivering mental health literacy programs to promote help-seeking. Messages promoting supervisor and colleague support for CO-delivered mental health literacy programs could potentially help in improving worker participation rates, particularly for those without previous associations with COs.

Control Beliefs

Third-party endorsement (n=7) was reported as a key facilitator to participation, but the type of entity deemed appropriate to provide such endorsement differed between the categories of workers. Workers with associations

with COs preferred recommendations from appropriately qualified organisations (n=2) and peak bodies (n=2), which suggests that they understood the benefit of such affiliations to enhance targeted outcomes. Peak bodies (i.e., Neighbourhood Houses Victoria), have the trust, reputation, resources[79], reach[17], and collaborative experience[80] required to coordinate the implementation of such programs and, therefore, could be useful in helping promote them more widely. Workers without associations referred to endorsement from government entities (n=3), which implies that were not aware of the benefit of affiliations and highlights the importance of having endorsements to fit audience expectations. What this does point to is the importance and potential of cross-sector collaborations with third parties such as government/statutory entities, organisations with work-related mental health expertise, peak bodies and COs, to promote, resource, facilitate, and enhance worker participation.

Limited access (n=10) encompassing time (n=6), and distance (n=4) constraints, was the most identified barrier for workers. Selecting and promoting COs that have the capacity to overcome these limitations through size, reach, delivery models (online and/or outside working hours) could potentially enhance worker participation rates. Another barrier identified was **lack of skills training and lived experiences of coordinators/facilitators** (n=5). Workers preferred facilitators that were qualified through training or experience to address work-related mental health literacy (n=3). Just relying on the celebrity status of a facilitator, without appropriate skills or experiences was identified as deterrent (n=2). None of the workers with associations with COs reported the celebrity status of a facilitator/speaker as a barrier. These workers may have been exposed to initiatives that have used people of note and, therefore, were not sceptical of their potential contribution. Research has shown that motivational talks given by notable speakers such as sportsmen have had a positive impact in the community in raising awareness of mental health, particularly on men's intentions to seek help[81]. Our findings indicate that the lived experience of work-related mental illness of a speaker could play a bigger role than their celebrity status in encouraging worker participation, particularly for those that did not have associations with COs. Promotion of programs/events delivered by qualified (skills and experience) coordinators/facilitators may alleviate some of the participation barriers.

Strengths and Limitations

This is the first TPB-based qualitative research that has explored the potential utility of a community-based approach to overcome workplace barriers to help-seeking for work-related mental injury through mental health literacy programs. Our study identified a range of worker attitudes and beliefs that indicate that COs are potentially a viable and complementary alternative to workplace-based programs for accessing mental health literacy programs and peer support.

The small convenience sample size of our study limits the transferability of findings. Response bias may be an issue due to participants being self-selecting and may be more motivated by goodwill than the average member of the population. Further, respondents were white-collar workers from large organisations located in a metropolitan area and may have different perspectives than those from smaller blue-collar organisations, or those located in remote/regional settings. Finally, this study was conducted during a global pandemic, which may have affected respondents' views surrounding mental health approaches within their workplace or wider community.

Future Research

Future research needs to identify COs that are best suited to deliver work-related mental health literacy programs based on the attributes, positioning, and governance structures that workers find appealing and investigate their appetite, capacity, and willingness to provide these programs through cross-sector collaborations. Research needs to explore the benefit of affiliations with relevant, and well-established bodies (i.e., peak bodies) and third-party endorsement of these initiatives via collaborative approaches for effective reach in the community. Future studies could replicate this study using a larger sample that is more representative of workers in general.

CONCLUSION

The current study used a well-founded psychological decision-making theory (TPB) to explore the motivation of workers to engage with mental health literacy programs delivered by COs. Workers with and without current or previous associations with COs were compared. Results showed that COs provide workers with an alternative to workplace settings to address work-related mental injury through mental health literacy programs. COs are seen as being suitable as they are empathetic, safe, relatable, trustworthy, supportive, and inclusive environments. Advantages of programs delivered by COs were discussing shared experiences with peers and the opportunity to receive independent perspectives and unbiased advice. Workers without associations with COs were not as aware of these benefits. Family and friends were most likely to approve of participating in such programs. Supervisors and colleagues were important social referents that might disapprove, therefore their support for these programs should be encouraged and communicated. Workers with associations with COs reported the lack of suitability and the legitimacy of leadership and governance of COs as limiting factors. COs that are appropriately structured, led, and governed should be identified to deliver these programs. Workers without associations referred to endorsement by government bodies whereas those with associations referred to endorsement by peak bodies and specialist organisations. Strategic alliances with appropriately positioned COs and third parties such as statutory entities, peak bodies, and organisations with work-related mental health literacy expertise should be explored to inform the development of a framework for cross-sector collaboration to support and promote mental health literacy programs delivered by COs.

Author affiliations

1 Corina Crisan, https://orcid.org/0000-0003-4186-0114
Monash Sustainable Development Institute, Monash University, Melbourne, Victoria, Australia

2 Pieter Andrew Van Dijk, ORCID: https://orcid.org/0000-0002-3110-9848
Monash Business School, Monash University, Melbourne, Victoria, Australia

3 Jennie Oxley, https://orcid.org/0000-0002-7519-1994
Monash University Accident Research Centre, Monash University, Melbourne, Victoria, Australia

4 Andrea De Silva
School of Public Health and Preventive Medicine, Monash University, Melbourne, Victoria, Australia

Competing interests

The authors declare that they have no competing interests.

Author contributions

CC, PAVD, JO and ADS developed the study idea. CC developed the study design and interview protocol, with PAVD providing theoretical expertise and guidance. CC conducted and transcribed the interviews, and PAVD confirmed accuracy. CC analysed the data, and PAVD and JO provided qualitative methods expertise on data analysis and data interpretation. CC drafted the manuscript with regular input from PAVD and JO. PAVD and JO reviewed the draft manuscript. All authors critically reviewed and approved the final version of the manuscript.

Funding

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Patient consent for publication

Not required.

Ethics approval

Ethical approval was obtained from the Monash University Human Research Ethics Committee (MUHREC) (project ID: 20548).

Data sharing statement

No additional data available.

SUPPLEMENTAL MATERIAL

Supplemental Material A: Questionnaire Worker

ATTRIBUTES OF COMMUNITY ORGANISATIONS

- What are your views about community organisations?
- How do you think community organisations can help address work-related mental injury?
- What is it about community organisations that would make them appealing to you as a mental health literacy program provider?

EXPERIENCES WITH COMMUNITY ORGANISATIONS

- What can you tell me about your experiences or involvement with such organisations?

BEHAVIOURAL BELIEFS

- What do you believe to be the advantages of participating in mental health literacy programs delivered by community organisations, should you have any work-related mental health concerns?
- What do you believe to be the disadvantages of participating in these community-based programs?

NORMATIVE BELIEFS

- Which individuals within your personal/social and work networks do you think would approve of you participating in mental health literacy programs delivered by community organisations, should you have any work-related mental health concerns?
- Which individuals would disapprove of you participating in these community-based programs?

CONTROL BELIEFS

- What would make it easier for you to participate in mental health literacy programs delivered by community organisations to address work-related mental health concerns?
- What would prevent you from participating in these community-based programs?

Supplemental Material B: Questionnaire Manager

ATTRIBUTES OF COMMUNITY ORGANISATIONS

- What are your views about community organisations?
- How do you think community organisations can help address work-related mental injury?
- What is it about community organisations that would make them appealing to you as a mental health literacy program provider?
- Would you be supportive of a community-based approach to work-related mental injury prevention? Why?

EXPERIENCES WITH COMMUNITY ORGANISATIONS

- What can you tell me about your experiences or involvement with such organisations?

REFERENCES

1 Potter R, O'Keeffe V, Leka S, *et al.* Analytical review of the Australian policy context for work-related psychological health and psychosocial risks. *Saf Sci* 2019;**111**:37–48. doi:10.1016/j.ssci.2018.09.012

2 Cocker F, Sanderson K, LaMontagne AD. Estimating the Economic Benefits of Eliminating Job Strain as a Risk Factor for Depression. *J Occup Environ Med* 2017;**59**:12–7. doi:10.1097/JOM.0000000000000908

3 Harvey SB, Deady M, Wang M-J, *et al.* Is the prevalence of mental illness increasing in Australia? Evidence from national health surveys and administrative data, 2001-2014. *Med J Aust* 2017;**206**:490–3. doi:10.5694/mja16.00295.

4 Productivity Commission. Mental Health. Report no. 95. Canberra, Australia: 2020. https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health.pdf

5 Safe Work Australia. Bullying & Harassment in Australian Workplaces: Results from the Australian Workplace Barometer Project 2014/2015. Canberra, Australia: 2016. doi:10.13140/RG.2.2.11119.43682

6 LaMontagne AD, Keegel T, Vallance D, *et al.* Job strain - Attributable depression in a sample of working Australians: Assessing the contribution to health inequalities. *BMC Public Health* 2008;**8**. doi:10.1186/1471-2458-8-181

7 Harvey SB, Modini M, Joyce S, *et al.* Can work make you mentally ill? A systematic meta-review of work-related risk factors for common mental health problems. *Occup Environ Med* 2017;**74**:301–10. doi:10.1136/oemed-2016-104015.

8 SafeWork NSW. Review of Evidence of Interventions to Reduce Mental Ill-health in the Workplace. 2017. https://www.safework.nsw.gov.au/__data/assets/pdf_file/0012/320232/Mentally-healthy-workplaces-in-NSW-discussion-paper-September-2017-SW08615.pdf

9 BeyondBlue. State of Workplace Mental Health in Australia. 2014. https://www.headsup.org.au/docs/default-source/resources/bl1270-report---tns-the-state-of-mental-health-in-australian-workplaces-hr.pdf?sfvrsn=8

10 Hanisch SE, Twomey CD, Szeto ACH, *et al.* The effectiveness of interventions targeting the stigma of mental illness at the workplace: a systematic review. *BMC Psychiatry* 2016;**16**:1–11. doi:10.1186/s12888-015-0706-4

11 Dewa CS, Hoch JS. Barriers to Mental Health Service Use among Workers with Depression and Work Productivity. *J Occup Environ Med* 2015;**57**:726–31. doi:10.1097/JOM.0000000000000472

12 Dewa CS, van Weeghel J, Joosen MCW, *et al.* Workers' Decisions to Disclose a Mental Health Issue to Managers and the Consequences. *Front Psychiatry* 2021;**12**:631032. doi:10.3389/fpsyt.2021.631032

13 LaMontagne AD, Milner AJ, Allisey AF, *et al.* An integrated workplace mental health intervention in a policing context: Protocol for a cluster randomised control trial. *BMC Psychiatry* 2016;**16**. doi:10.1186/s12888-016-0741-9

14 Tynan RJ, Considine R, Rich JL, *et al.* Help-seeking for mental health problems by employees in the Australian Mining Industry. *BMC Health Serv Res* 2016;**16**:498. doi:10.1186/s12913-016-1755-1

15 Ammendolia C, Côté P, Cancelliere C, *et al.* Healthy and productive workers: using intervention mapping to design a workplace health promotion and wellness program to improve presenteeism. *BMC Public Health* 2016;**16**:1190. doi:10.1186/s12889-016-3843-x

16 Productivity Commission. Contribution of the Not-for-Profit Sector. Research Report. Canberra, Australia: 2010. https://www.pc.gov.au/inquiries/completed/not-for-profit/report/not-for-profit-report.pdf

17 Lyons A, Fletcher G, Farmer J, *et al.* Participation in rural community groups and links with psychological well-being and resilience: a cross-sectional community-based study. *BMC Psychol* 2016;**4**. doi:10.1186/s40359-016-0121-8

18 Jorm AF, Korten AE, Jacomb PA, *et al.* 'Mental health literacy': A survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Med J Aust* 1997;**166**:182–6. doi:10.5694/j.1326-5377.1997.tb140071.x

19 Moll SE, Patten S, Stuart H, *et al.* Beyond Silence: A Randomized, Parallel-Group Trial Exploring the Impact of Workplace Mental Health Literacy Training with Healthcare Employees. *Can J Psychiatry* 2018;**63**:826–833. doi:10.1177/0706743718766051

20 Szeto ACH, Dobson KS. Reducing the stigma of mental disorders at work: A review of current workplace anti-stigma intervention programs. *Appl Prev Psychol* 2010;**14**:41–56. doi:10.1016/j.appsy.2011.11.002

21 Compton RL, McManus JG. Employee Assistance Programs in Australia: Evaluating Success. *J Workplace Behav Health* 2015;**30**:32–45. doi:10.1080/15555240.2015.998971

22 Brouwers EPM, Joosen MCW, van Zelst C, *et al.* To Disclose or Not to Disclose: A Multi-stakeholder Focus Group Study on Mental Health Issues in the Work Environment. *J Occup Rehabil* 2020;**30**:84–92. doi:10.1007/s10926-019-09848-z

23 Gayed A, Milligan-Saville JS, Nicholas J, *et al.* Effectiveness of training workplace managers to understand and support the mental health needs of employees: A systematic review and meta-analysis. *Occup Environ Med* 2018;**75**:462–70.

24 LaMontagne AD, Martin A, Page KM, *et al.* Workplace mental health: Developing an integrated intervention approach. *BMC Psychiatry* 2014;**14**. doi:10.1186/1471-244X-14-131

25 Reupert A. Enhancing workforce capacity in mental health promotion, prevention and early intervention. *Adv Ment Heal* 2018;**16**:1–4. doi:10.1080/18387357.2018.1429196

26 Reavley NJ, Morgan AJ, Jorm AF. Predictors of experiences of discrimination and positive treatment in people with mental health problems: findings from an Australian national survey. *Soc Psychiatry Psychiatr Epidemiol* Published Online First: 2017. doi:10.1007/s00127-016-1301-9

27 Moll SE. The web of silence: A qualitative case study of early intervention and support for healthcare workers with

mental ill-health. *BMC Public Health* 2014;**14**. doi:10.1186/1471-2458-14-138

28 Brohan E, Evans-Lacko S, Henderson C, *et al.* Disclosure of a mental health problem in the employment context: Qualitative study of beliefs and experiences. *Epidemiol Psychiatr Sci* 2014;**23**:289–300. doi:10.1017/S2045796013000310

29 Stratton E, Einboden R, Ryan R, *et al.* Deciding to disclose a mental health condition in male dominated workplaces; a focus-group study. *Front Psychiatry* 2018;**9**:1–10. doi:10.3389/fpsyt.2018.00684

30 National Mental Health Commission. Developing a mentally healthy workplace: A review of the literature. 2014. https://www.headsup.org.au/docs/default-source/resources/developing-a-mentally-healthy-workplace_final-november-2014.pdf?sfvrsn=8

31 Bovopoulos N, Lamontagne AD, Martin A, *et al.* Exploring the role of mental health first aid officers in workplaces. A qualitative study using case study methodology. *Int J Work Heal Manag* 2018;**11**:366-381. doi:10.1108/IJWHM-06-2018-0082

32 Laverack G. Health activism. *Health Promot Int* 2012;**27**:429–34. doi:10.1093/heapro/das044

33 Rossetto A, Potts LC, Reavley NJ, *et al.* Perceptions of positive treatment and discrimination toward people with mental health problems: Findings from the 2017 and 2019 attitudes to mental illness surveys. *Stigma Heal* 2019;**273**:141-148. doi:10.1016/j.psychres.2019.01.027

34 Gardner A, Cotton SM, Allott K, *et al.* Social inclusion and its interrelationships with social cognition and social functioning in first-episode psychosis. *Early Interv Psychiatry* 2019;**13**:477–87. doi:10.1111/eip.12507

35 Filia KM, Jackson HJ, Cotton SM, *et al.* What is social inclusion? A thematic analysis of professional opinion. *Psychiatr Rehabil J* 2018;**41**:183–95. doi:10.1111/eip.12507

36 Ross AM, Bassilios B. Australian R U OK?Day campaign: Improving helping beliefs, intentions and behaviours. *Int J Ment Health Syst* 2019;**13**. doi:10.1186/s13033-019-0317-4

37 Wilson NJ, Cordier R. A narrative review of Men's Sheds literature: Reducing social isolation and promoting men's health and well-being. *Heal Soc Care Community* 2013;**21**:451–63. doi:10.1111/hsc.12019

38 Syzdek MR, Addis ME, Green JD, *et al.* A pilot trial of gender-based motivational interviewing for help-seeking and internalizing symptoms in men. *Psychol Men Masculinity* 2014;**15**:90–94. doi:10.1037/a0030950

39 Couture SM, Penn DL. Interpersonal contact and the stigma of mental illness: A review of the literature. *J Ment Heal* 2003;**12**:291–305. doi:10.1080/09638231000118276

40 Mead S, Filson B. Mutuality and shared power as an alternative to coercion and force. *Ment Heal Soc Incl* 2017;**21**:144–52. doi:10.1108/MHSI-03-2017-0011

41 Whiteford GE, Pereira RB. Occupation, Inclusion and Participation. In: Whiteford, G. & Hocking C, ed. *Occupational Science: Society, Inclusion, Participation*. Wiley Blackwell 2012. 185–207.

42 Tomczyk S, Schomerus G, Stolzenburg S, *et al.* Ready, Willing and Able? An Investigation of the Theory of Planned Behaviour in Help-Seeking for a Community Sample with Current Untreated Depressive Symptoms. *Prev Sci* 2020;**21**:749–760. doi:10.1007/s11121-020-01099-2

43 White MM, Clough BA, Casey LM. What do help-seeking measures assess? Building a conceptualization framework for help-seeking intentions through a systematic review of measure content. *Clin Psychol Rev* 2018;**59**:61–77. doi:10.1016/j.cpr.2017.11.001

44 Rickwood D, Thomas K. Conceptual measurement framework for help-seeking for mental health problems. *Psychol Res Behav Manag* 2012;**5**:173–183. doi:10.2147/PRBM.S38707

45 Fishbein M, Ajzen I. *Predicting and Changing Behavior: The Reasoned Action Approach (1st ed.)*. NY: Psychology Press 2009. doi:10.4324/9780203838020

46 Ajzen I. The theory of planned behavior. *Organ Behav Hum Decis Process* 1991;**50**:179–211. doi:10.1016/0749-5978(91)90020-T

47 Ajzen I, Fishbein M. *Understanding Attitudes and Predicting Social Behavior*. Englewood Cliffs, N.J.: Prentice-Hall 1980.

48 O'Brien BC, Harris IB, Beckman TJ, *et al.* Standards for reporting qualitative research: A synthesis of recommendations. *Acad Med* 2014;**89**:1245–51. doi:10.1097/ACM.0000000000000388

49 O'Sullivan D, Rahamathulla M, Pawar M. The Impact and Implications of COVID-19: An Australian Perspective. *Int J Community Soc Dev* 2020;**2**:134–51. doi:10.1177/2516602620937922

50 Patton MQ. *Qualitative Research and Evaluation Methods: Integrating Theory and Practice (4th ed)*. SAGE Publications: Thousand Oaks, US. 2015.

51 Saumure K, Given LM. Data Saturation. In: Given LM, ed. *The SAGE Encyclopedia of Qualitative Research Methods*. SAGE Publications Inc 2008. 195–6.

52 QSR International Pty Ltd. NVivo qualitative data analysis Software (released in March 2020). 2020.https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

53 Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;**3**:77–101. doi:10.1191/1478088706qp063oa

54 Boyatzis RE. *Transforming qualitative information: thematic analysis and code development*. Thousand Oaks, CA: Sage Publications 1998.

55 Nowell LS, Norris JM, White DE, *et al.* Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *Int J Qual*

Methods 2017;**16**. doi:10.1177/1609406917733847

56 Miles MB, Huberman a M. *Qualitative Data Analysis: An expanded sourcebook (2nd ed.)*. Thousand Oaks, CA: Sage Publications. 1994.

57 Hardeman W, Johnston M, Johnston D, *et al.* Application of the theory of planned behaviour in behaviour change interventions: A systematic review. *Psychol Heal* 2002;**17**:123–58. doi:10.1080/08870440290013644a

58 Davis MH. Measuring individual differences in empathy: Evidence for a multidimensional approach. *J Pers Soc Psychol* 1983;**44**:113–26. doi:10.1037/0022-3514.44.1.113

59 Martinez AG. When "They" Become "I": Ascribing Humanity to Mental Illness Influences Treatment-Seeking for Mental/Behavioral Health Conditions. *http://dx.doi.org/101521/jscp2014332187* 2014;**33**:187–206. doi:10.1521/JSCP.2014.33.2.187

60 O'donovan R, Mcauliffe E. A systematic review of factors that enable psychological safety in healthcare teams. *Int J Qual Heal Care* 2020;**32**:240–50. doi:10.1093/INTQHC/MZAA025

61 South J, Bagnall A-M, Stansfield JA, *et al.* An evidence-based framework on community-centred approaches for health: England, UK. *Health Promot Int* 2017;**34**:356–66. doi:10.1093/heapro/dax083.

62 Levesque JF, Harris MF, Russell G. Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *Int J Equity Health* 2013;**12**. doi:https://doi.org/10.1186/1475-9276-12-18

63 Sekhon M, Cartwright M, Francis JJ. Acceptability of healthcare interventions: An overview of reviews and development of a theoretical framework. *BMC Health Serv Res* 2017;**17**:1–13. doi:10.1186/s12913-017-2031-8

64 Saurman E. Improving access: Modifying Penchansky and Thomas's theory of access. *J Heal Serv Res Policy* 2016;**2**:36–39. doi:10.1177/1355819615600001

65 Shengelia B, Murry CJ, Adams OB. Beyond Access and Utilization: Defining and Measuring Health System Coverage. In: Murray CJL ED, ed. *Health systems performance assessment. Debates, Methods and Empiricism*. Geneva: World Health Organization 2003. 221–34.

66 Leamy M, Bird V, Boutillier C Le, *et al.* Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *Br J Psychiatry* 2011;**199**:445–52. doi:10.1192/BJP.BP.110.083733

67 WS Y, N H, A H, *et al.* Igniting and Maintaining Hope: The Voices of People Living with Mental Illness. *Community Ment Health J* 2020;**56**:1044–52. doi:10.1007/S10597-020-00557-Z

68 Townsend SSM, Kim HS, Mesquita B. Are You Feeling What I'm Feeling? Emotional Similarity Buffers Stress. *Soc Psychol Personal Sci* 2014;**5**:526–33. doi:10.1177/1948550613511499

69 Peck CE, Lim MH, Purkiss M, *et al.* Development of a Lived Experience-Based Digital Resource for a Digitally-Assisted Peer Support Program for Young People Experiencing Psychosis. *Front Psychiatry* 2020;:635. doi:10.3389/FPSYT.2020.00635

70 Honey A, Boydell KM, Coniglio F, *et al.* Lived experience research as a resource for recovery: a mixed methods study. *BMC Psychiatry 2020 201* 2020;**20**:1–13. doi:10.1186/S12888-020-02861-0

71 Taylor J, Jones RM, O'Reilly P, *et al.* The Station Community Mental Health Centre Inc: nurturing and empowering. *Rural Remote Health* 2010;**10**:1–12. doi:10.22605/RRH1411

72 Lingard H, Francis V. The work-life experiences of office and site-based employees in the Australian construction industry. *Constr Manag Econ* 2004;**22**:991–1002.

73 Azzone V, McCann B, Merrick EL, *et al.* Workplace stress, organizational factors and EAP utilization. *J Workplace Behav Health* 2009;**24**:344–56. doi:10.1080/15555240903188380

74 Walton L. Exploration of the attitudes of employees towards the provision of counselling within a profit-making organisation. *Couns Psychother Res* 2003;**3**:65–71. doi:10.1080/14733140312331384658

75 Deyo-Svendsen ME, Palmer KB, Albright JK, *et al.* Provider Approachability: An All-Staff Survey Approach to Creating a Culture of Safety. *J Patient Saf* 2019;**15**:e64–9. doi:10.1097/PTS.0000000000000409

76 Peters E, Spanier K, Radoschewski FM, *et al.* Influence of social support among employees on mental health and work ability—a prospective cohort study in 2013–15. *Eur J Public Health* 2018;**28**:819–23. doi:10.1093/eurpub/cky067

77 Jung H, von Sternberg K, Davis K. The impact of mental health literacy, stigma, and social support on attitudes toward mental health help-seeking. *Int J Ment Health Promot* 2017;**19**:252–67. doi:10.1080/14623730.2017.1345687

78 Joyce T, Hazelton M, McMillan M. Nurses with mental illness: Their workplace experiences. *Int J Ment Health Nurs* 2007;**16**:373–80. doi:10.1111/j.1447-0349.2007.00492.x.

79 Melville R, Rose. The state and community sector peak bodies: theoretical and policy challenges. *Third Sect Rev* 1999;**5**:25–41.

80 Roberts R, Lockett H, Bagnall C, *et al.* Improving the physical health of people living with mental illness in Australia and New Zealand. *Aust J Rural Health* 2018;**26**:354–62. doi:10.1111/ajr.12457

81 Harding C, Fox C. It's Not About "Freudian Couches and Personality Changing Drugs": An Investigation Into Men's Mental Health Help-Seeking Enablers. *Am J Mens Health* 2015;**9**:451–63. doi:10.1177/1557988314550194.

Supplemental Material A

Questionnaire Worker

ATTRIBUTES OF COMMUNITY ORGANISATIONS

- What are your views about community organisations?
- How do you think community organisations can help address work-related mental injury?
- What is it about community organisations that would make them appealing to you as a mental health literacy program provider?

EXPERIENCES WITH COMMUNITY ORGANISATIONS

- What can you tell me about your experiences or involvement with such organisations?

BEHAVIOURAL BELIEFS

- What do you believe to be the advantages of participating in mental health literacy programs delivered by community organisations, should you have any work-related mental health concerns?
- What do you believe to be the disadvantages of participating in these community-based programs?

NORMATIVE BELIEFS

- Which individuals within your personal/social and work networks do you think would approve of you participating in mental health literacy programs delivered by community organisations, should you have any work-related mental health concerns?
- Which individuals would disapprove of you participating in these community-based programs?

CONTROL BELIEFS

- What would make it easier for you to participate in mental health literacy programs delivered by community organisations to address work-related mental health concerns?
- What would prevent you from participating in these community-based programs?

Supplemental Material B

Questionnaire Manager

ATTRIBUTES OF COMMUNITY ORGANISATIONS

- What are your views about community organisations?
- How do you think community organisations can help address work-related mental injury?
- What is it about community organisations that would make them appealing to you as a mental health literacy program provider?
- Would you be supportive of a community-based approach to work-related mental injury prevention? Why?

EXPERIENCES WITH COMMUNITY ORGANISATIONS

- What can you tell me about your experiences or involvement with such organisations?

Standards for Reporting Qualitative Research (SRQR) - Checklist

No.	Topic	Item	Page
Title and abstract			
S1	Title	Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	1
S2	Abstract	Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	2
Introduction			
S3	Problem formulation	Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	4 - 5
S4	Purpose or research question	Purpose of the study and specific objectives or questions	5
Methods			
S5	Qualitative approach and research paradigm	Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/interpretivist) is also recommended; rationale	5 - 6
S6	Researcher characteristics and reflexivity	Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	7 - 8
S7	Context	Setting/site and salient contextual factors; rationale	6
S8	Sampling strategy	How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale	6 - 7
S9	Ethical issues pertaining to human subjects	Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	7
S10	Data collection methods	Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale	6
S11	Data collection instruments and technologies	Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	6 – 7, 16 – 17: Supplemental material
S12	Units of study	Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	7, Table 1
S13	Data processing	Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/deidentification of excerpts	7 - 8
S14	Data analysis	Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale	7 - 8
S15	Techniques to enhance trustworthiness	Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale	8
Results/findings			
S16	Synthesis and interpretation	Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	8

No.	Topic	Item	Page
S17	Links to empirical data	Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	9 - 10 Tables 2 and 3
Discussion			
S18	Integration with prior work, implications, transferability, and contribution(s) to the field	Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	11 - 14
S19	Limitations	Trustworthiness and limitations of finding	13
Other			
S20	Conflicts of interest	Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	15
S21	Funding	Sources of funding and other support; role of funders in data collection, interpretation, and reporting	15

Reference:

O'Brien BC, Harris IB, Beckman TJ, *et al.* Standards for reporting qualitative research: A synthesis of recommendations. *Acad Med* 2014;**89**:1245–51. doi:10.1097/ACM.0000000000000388

BMJ Open

Worker and manager perceptions of the utility of work-related mental health literacy programs delivered by community organisations: a qualitative study based on the theory of planned behaviour

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2021-056472.R1
Article Type:	Original research
Date Submitted by the Author:	28-Dec-2021
Complete List of Authors:	Crisan, Corina; Monash University, Monash Sustainable Development Institute Van Dijk, Pieter; Monash University, Monash Business School Oxley, Jennie; Monash University, Monash University Accident Research Centre De Silva, Andrea; Monash University, School of Public Health and Preventive Medicine
Primary Subject Heading:	Mental health
Secondary Subject Heading:	Public health, Qualitative research
Keywords:	MENTAL HEALTH, Health policy < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Health & safety < HEALTH SERVICES ADMINISTRATION & MANAGEMENT

I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our licence.

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which Creative Commons licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

TITLE

Worker and manager perceptions of the utility of work-related mental health literacy programs delivered by community organisations: a qualitative study based on the theory of planned behaviour

1 Corina Crisan

2 Pieter Andrew Van Dijk

3 Jennie Oxley

4 Andrea De Silva

Corresponding author

Correspondence to Corina Crisan, email: corina.crisan@monash.edu, mobile: +61 466688138

Word count:

4,407

Keywords

mental injury, workers, managers, help-seeking, mental health literacy, community-based approach, community organisations, Theory of Planned Behaviour, underlying beliefs

ABSTRACT

Objectives

Reluctance to seek help is a leading contributor to escalating mental injury rates in Australian workplaces. We explored the benefit of using community organisations to deliver mental health literacy programs to overcome workplace barriers to help-seeking behaviours.

Design

This study used a qualitative application of The Theory of Planned Behaviour to examine underlying beliefs that may influence worker's intentions to participate in mental health literacy programs delivered by community organisations, and manager support for them.

Setting

This study took place within three large white-collar organisations in the Australian state of Victoria.

Participants

Eighteen workers and eleven managers (n=29) were interviewed to explore perspectives of the benefits of such an approach.

Results

Community organisations have six attributes that make them suitable as an alternative mental health literacy program provider including empathy, safety, relatability, trustworthiness, social support, and inclusivity. Behavioural beliefs included accessibility, understanding, and objectivity. The lack of suitability and legitimacy due to poor governance and leadership were disadvantages. Normative beliefs were that family and friends would most likely approve, while line managers and colleagues were viewed as most likely to disapprove. Control beliefs indicated that endorsements from relevant bodies were facilitators of participation. Distance/time constraints, and the lack of skills, training and lived experiences of coordinators/facilitators were seen as barriers.

Conclusions

Identifying workers' beliefs and perceptions of community organisations has significant implication for the development of effective community-based strategies to improve worker mental health literacy, and help-seeking. Organisations with formal governance structures, and allied with government, peak bodies and work-related mental health organisations would be most suitable. Approaches should focus on lived experience and be delivered by qualified facilitators. Promoting supervisor and colleague support could improve participation. Models to guide cross-sector collaborations to equip community organisations to deliver work-related mental health literacy programs need to be explored.

ARTICLE SUMMARY

Strengths and limitations of this study

- This is the first study that used a qualitative framework to explore worker and manager perceptions of the benefit of using community organisations to deliver mental health literacy programs to support the prevention of, and recovery from work-related mental injury.
- Understanding the underlying beliefs influencing workers' participation in mental health literacy programs delivered by community organisations using a psychological theory-based decision-making model (Theory of Planned Behaviour), is critical for the development of effective strategies to improve engagement rates.
- Mental health literacy programs delivered by community organisations could help overcome some of the barriers to seeking help associated with the workplace such as fear of discrimination and unsupportive work cultures.
- The small sample size may limit the transferability of findings.
- White-collar workers from large organisations located in a metropolitan area may have different beliefs than those from blue-collar, smaller organisations or located in remote or regional settings.

INTRODUCTION

Reluctance to seek help is a leading contributor for escalating mental injury rates in Australian workplaces[1–3]. The financial cost of work-related mental injuries to Australian workplaces is significant, estimated to be more than $12 billion per year in lost productivity[4]. Work-related mental injuries are associated with work-related factors such as job demand and pressure, harassment, bullying, exposure to violence or traumatic events, and interpersonal conflict[5–7]. Many workers are reluctant to use the mental health programs and support mechanisms provided by their workplace[8,9]. Attitudinal barriers to help-seeking include stigma, unrecognized need for help, preference for self-reliance, and belief that treatment would be ineffective[10,11]. Workplace barriers include mistrust of embedded programs such as Employee Assistant Programs, fear of discrimination or repercussion on their career, limited confidence in managers' capabilities surrounding disclosure, and unsupportive organisational cultural norms[12–15]. Furthermore, structural barriers such as the unavailability of service providers outside working hours can also affect access to care[11].

The escalating work-related mental injury rates[4] warrant exploration of alternative ways to reach workers who may be unwilling, or unable, to access organisational and public health support before their mental health concerns reach unhealthy levels. Currently under-explored is the utility of community organisations (COs) to deliver work-related mental health literacy programs designed to address barriers to help-seeking behaviours. These organisations are non-governmental, not-for-profit, that operate for social purposes[16], are accessible and trusted sources of support, and have reach into many sections of the community[17]. COs, such as sporting clubs, Men's Sheds and Neighbourhood Houses, currently provide support for people within the community for a broad range of mental health problems through literacy training and guest speaker events that are designed to destigmatise mental illness and encourage help-seeking, but do not directly address work-related mental health and worker-specific needs[17–19]. A community-based approach using COs to deliver mental health literacy programs could conceivably be more appealing and effective than organisational initiatives.

Mental health literacy refers to knowledge about mental illness and the skills required to recognise, manage, and/or prevent it[20]. The lack of mental health literacy is a key barrier to help-seeking of workers[21,22]. Building workers' capacity/capability to recognise the symptoms of mental injury and access professional support is critical for addressing workplace-induced mental ill-health[11,23,24]. Many programs such as such as Mental Health First Aid (MHFA)[25] promote prevention, self-management and help-seeking for mental ill-health. These interventions often use people with a lived experience of mental injury[26,27] and can take a variety of forms ranging from general awareness events (R U OK?Day)[18] through to structured programs, training modules, and information sessions[21] over the course of multiple hours or days. MHFA training has been effective in reducing mental health stigma, and improving participants' knowledge, attitudes, skills, and confidence to seek professional help[10,20,25,28–32]. Building on evidence of their effectiveness, many employers have implemented mental health literacy programs[8,21,30,33,34] and use these initiatives to promote pathways and referrals to professional services offered by workplaces or public health practitioners[35]. Though these efforts have increased literacy levels of workers[24,36], evidence suggests this has not resulted in supportive attitudes or behaviours in the workplace[37] and therefore low disclosure rates in workplaces are still a problem in addressing work-related mental injuries[9,38].

Previous studies have demonstrated that supportive social referents can be beneficial in the help-seeking process[8,39]. An encouraging environment will facilitate workers' confidence, and the development of tools required to seek timely access to mental health treatment[37]. A supportive workplace management culture exhibiting positive attitudes toward mental health can facilitate workers' willingness to disclose mental health problems[40]. Evidence suggests however that support in many workplaces is insufficient to overcome worker reluctance to seek help. For example, a study has shown that perceptions of bias, role conflict, and hierarchical relationships between the help provider and recipient significantly impact disclosure rates[41]. Importantly, a perceived lack of genuine care and support can contribute to a worker's exclusion, leaving them feeling isolated[37,42,43]. The limitations of current approaches point to the need to explore solutions that can provide the level of support required to encourage workers' help-seeking behaviours.

Such an opportunity may exist in adopting a more socially inclusive approach at a community level[44,45]. A strength of a community-based approach is the practical advice provided by peers with lived experience with no perceived inequality in the power relationship. This has been found to significantly improve participants' recognition of emotional problems, confidence, and coping skills[46–48]. In the context of work-related mental injury, this could involve providing work-focused programs tailored to worker needs delivered outside of workplace settings. As COs have a large reach and are an integral part of the Australian social fabric, they are well-placed to be a vehicle to reach disadvantaged and isolated workers by providing tailored opportunities to access mental health literacy programs to overcome barriers to help-seeking[49]. What needs to be determined is if such an approach has any appeal or perceived benefit.

Theory of Planned Behaviour

To address the identified gaps in the literature, this study applied the Theory of Planned Behaviour (TPB), a theory-based and robust decision-making model that is the most applied framework to better understand decision-making and behaviour change[50–54]. The TPB posits that intention to perform a behaviour is primarily guided by three constructs. These are attitude (overall evaluation of participation), subjective norms (perceived social pressure associated with participation), and perceived behavioural control (the perceived degree of ease or difficulty to participate). Each of these constructs are influenced by the associated underlying beliefs, including behavioural beliefs (advantages and disadvantages of participation), normative beliefs (key referents who approve or disapprove of such participation), and control beliefs (barriers or facilitators to participation). The TPB is used in this study as an evidence-based framework for examining key beliefs influencing worker attitudes and intentions toward making use of the proposed CO-delivery of mental health literacy programs. A key strength of the TPB is that it facilitates identification of beliefs that differentiate users and non-users[55], which can help in the development of targeted strategies to facilitate decision making/behaviour change[53].

The Current Study

The objective of this study is to determine the potential utility of using COs to deliver work-related mental health literacy programs to help overcome workplace barriers to help-seeking. The two aims associated with this objective are (1) to explore attributes of COs that make them suitable to deliver work-related mental health literacy programs from the perspective of workers (as a potential user) and managers (as an important social referent), and (2) to examine the motivations that influence worker intentions to potentially participate in such programs, including how prior or current associations with COs may influence these motivations.

To the authors' knowledge, no previous studies have used the TPB to explore the factors influencing workers' potential participation in CO-delivered mental health literacy programs, or to explore perceptions of a key social referent group (managers) toward such an approach. It is anticipated that the results of this study will inform opportunities for cross-sector collaborations to promote and enhance worker participation in mental health literacy programs delivered by COs for the prevention of, and recovery from work-related mental injury.

METHODS

Guidelines developed by O'Brien, Harris, Beckman et al (2014) were followed to ensure the transparency of reporting on research design and methods of data collection and analysis[56].

Procedure

CEOs or HR/OHS Managers from twenty-seven large organisations (with 200+ workers) in the Australian state of Victoria with comprehensive mental health programs in place were contacted by email with an invitation to participate in the study. The information included that the purpose of the interviews was to explore perceptions of workers and managers within the organisation about the potential utility of mental health literacy programs delivered by COs to address barriers to help-seeking for work-related mental injury. The invitation established that no mental health assessment would be conducted, participation was anonymous, voluntary, and information collected would be confidential. No reimbursements were provided. Out of twenty-seven organisations, nine initially responded (33%) however only three workplaces finally participated (11%) due to challenges related to COVID-19. The information flyer and consent form were distributed through formal organisational communication channels, as approved by the Monash University Human Research Ethics Committee (project ID: 20548). Selection criteria for workers included any full or part-time staff in a permanent or contracted role and who had been employed with the organisation for at least 6 months. Managers were invited based on their level of seniority within the organisation (executive or senior managers) and/or expertise in HR/OHS (convenience sample). The first author contacted respondents who expressed interest to confirm their eligibility. Informed consent was obtained from all participants prior to data collection.

The interviews were conducted via video platforms (Zoom/Microsoft Teams) due to COVID-19 physical distancing restrictions at the time of data collection[57]. The purpose of the research was explained, and demographic information was collected. Participants were informed that they could withdraw from the study at any time. Established interview protocols and techniques were followed to minimise interviewer and response bias[58]. Twenty-nine interviews were conducted over a four-month period between January and April 2020. Interviews were audio-recorded (average duration 46 minutes). Field notes were made following each interview to document the interviewer's impressions and ensure reflexivity[58]. Data collection ceased at the point of data saturation[59]. The transcriptions were stored on a password-protected computer to which only the first two authors had access.

Materials

At the beginning of each interview, participants were provided with a definition of mental health literacy. We described current CO initiatives that provide mental health literacy programs addressing general mental health awareness. In addition to general questions exploring managers' and workers' views of, and workers' prior or

current associations with COs, a belief elicitation interview protocol was used to explore workers' underlying beliefs about using mental health literacy programs delivered by COs (see supplemental material A). Interviews included open-ended questions and a conversational style to allow in-depth examination of participants' perceptions and experiences[58]. To explore underlying behavioural beliefs, workers were asked about advantages and disadvantages of attending these programs if the need arose. Normative beliefs were identified through questions about the role of significant people within their social and work networks in their decision to participate in these programs. Control beliefs were explored through questions focusing on what made it easier or more difficult for workers to participate, and what encouraged or prevented them from using such opportunities. Probing questions were used when needed to clarify the responses, gain further insights, and overcome researcher bias[48]. Managers with HR/OHS experience were interviewed to understand how mental health literacy programs delivered by COs might be perceived and supported in workplaces. Particularly, to understand whether they believed such approaches would complement existing workplace-based programs, and/or overcome some of the perceived access barriers associated with these programs (see supplemental material B). The interview protocols were piloted with three workers and two managers from the research team's professional network and subsequently refined prior to commencing data collection. This data was excluded from the analysis.

Participants

Participants (n=29; 16 female, 13 male) of which eighteen workers and eleven managers were aged 29–64 years. Eighteen participants worked in the public sector and eleven in the private sector. Nineteen participants were employed in an ongoing role, with the remainder in a contracting role. Participants were also classified as 'With Associations' (A) or 'Without Associations' (WA) depending on whether they had prior or current associations with COs or not. Table 1 shows the key demographic details of participants.

Table 1 *Demographic Characteristics of Study Participants*

		Workers; n (%)	Managers; n (%)
Associations with COs	With associations (prior/current)	9 (50%)	5 (45.5%)
	Without associations	9 (50%)	6 (54.5%)
Gender	Female	11 (61.1%)	5 (45.5%)
	Male	7 (38.9%)	6 (54.5%)
Age	25-34	1 (5.6%)	0 (0%)
	35-44	5 (27.8%)	5 (45.5%)
	45-54	6 (33.3%)	3 (27.2%)
	55-64	6 (33.3%)	3 (27.2%)
Employment Tenure	Permanent	13 (72.2%)	6 (54.5%)
	Contracted	5 (27.8%)	5 (45.5%)
Industry	Public sector	12 (66.6%)	6 (54.5%)
	Private sector	6 (33.4%)	5 (45.5%)

Patient and Public Involvement

This study involved no patients, only members of the public who were in active employment. No assessment was made on their current or past mental health state. In accordance with the ethics approval, each participant was provided with an information sheet containing the research team's contact details.

Data Analysis

All interview responses were transcribed verbatim by the first author, then confirmed for accuracy by the second author and imported into NVivo 12 software[60]. Each interview transcript was deidentified and assigned a unique code (W-worker, M-manager). Braun & Clarke's six-stage thematic approach (familiarisation with the data, coding, searching for themes from the codes, reviewing themes, defining and naming themes, and writing up the themes)[61] was used to identify and interpret patterns within data. Data analysis was both inductively and deductively compared to the TPB framework[62].

The first author coded responses of a subset of interview transcripts (n=5) using the TPB framework and constructs (behavioural beliefs, normative beliefs, and control beliefs). Field notes that were written following each interview were subsequently used in data analysis discussions among research team members to overcome any potential biases[58]. The initial codes were checked for emerging patterns and grouped into a draft framework of themes that were semantically close to the participants' wording[63]. Where applicable, themes were further split into sub-themes. The validity of these themes and sub-themes was checked by the second and third authors who have expertise in qualitative methods. It was determined that they were relevant to the research questions and representative of the data[61]. The framework was then applied to the remaining transcripts, whilst allowing for emergent themes until no new themes could be determined[64].

As the fieldwork and data analysis progressed, transcripts were reviewed systematically by the team's qualitative experts, and themes were refined iteratively based on recurrence and their relationship to each other. Any differences of opinion were discussed until consensus was reached among the research team. Once themes and sub-themes were confirmed, data was explored to identify common themes and understand the relationship between them[61]. Inter-rater reliability reached 90 per cent agreement[64].

RESULTS

Table 2 summarises workers' and managers' views about the attributes of COs that make them suitable for providing work-related mental health literacy programs with supporting quotes. Empathy, safety, relatability, trustworthiness, social support, and inclusivity were reported as appealing attributes of COs. Table 3 summarises the findings by the TPB belief categories. These are further divided by workers with associations with COs and those without, with supporting quotes. For the behavioural beliefs, the most reported advantages of participation in programs delivered by COs included accessibility (acceptability and approachability), understanding (hearing peers' lived experiences of work-related mental injury and sharing of lived experience with peers), and objectivity (unbiased by organisational goals and independent from workplaces). None of the workers without associations reported sharing of lived experience with peers, and being independent from workplaces as advantages. The lack of legitimacy (leadership and governance), and lack of suitability were

reported as disadvantages. No worker without associations mentioned issues surrounding leadership. For the normative beliefs, family and friends were reported as the social referents most likely to approve, while line managers and co-workers were viewed as most likely to disapprove of such participation. For the control beliefs, third-party endorsement was the most reported facilitator. Affiliations with peak organisations, or those with work-related mental health expertise were reported by workers with prior or current associations with COs. Those without associations reported endorsement by government bodies. Limited access (distance and time constraints), and the lack of skills, training and lived experiences of coordinators/facilitators (unqualified, celebrity) were the commonly reported barriers.

Table 2 *Attributes of Community Organisations*

Themes	Sub-themes	Workers n= 18	Managers n = 11	Representative Quotes
Empathy (n=13)	Person-centred (n=8)	4	4	Community organisations are so good at looking after the person and delivering a person centric service. (M4, WA*)
	Caring (n=5)	4	1	Those people, especially if they are members of community groups like CWA, are more empathetic. Those group members are there to be part of a social group and to participate in society. They are not fly fishing by themselves or looking for some rich boys' club reasons to participate. (W4, A**)
Safety (n=12)	Outside of workplace setting (n=6)	3	3	One of the things that would be appealing to seek community-based support for mental health issues is that it's separate from your workplace. (M3, A)
	Confidential (n=5)	2	3	It's about having that confidence that what's said in the room stays in the room. (W1, WA)
	Positive (n=1)	1	0	Something like a men's shed that has a really positive kind of vibe, a positive atmosphere and it's safe, that would be good. (W17, A)
Relatability (n=12)	Non-clinical and less stigmatising setting (n=8)	4	4	I think these organisations could help make mental health something that people talked about more freely because they've got less stigma about it, so you don't feel like there's something wrong with you as when you go to a professional. (W10, WA)
	Including people to which participants could relate (n=4)	3	1	Having an organisation with people that actually have lived experience that can be advocates of reaching out to people with similar issues, who can actually explain 'this is how I went through it', it's important. (W13, WA)
Trustworthiness (n=11)	Unbiased by organisational goals (n=6)	2	4	Having someone who's not biased, who is not invested either way, who can sit back, and listen in a way that's not judgmental, getting them to tell their story, to open up. I think in the workplace it's difficult to achieve that. (M6, WA)
	Independent from workplaces (n=5)	3	2	They are independent, and that's what makes their message so powerful. It goes back to trust and that's where the community organisations fit in. (W17, A)
Social support (n=9)	Social connection (n=5)	4	1	If you really struggle with work, or is something awful going on there, you know that you've got another thing that supports you. (W9, A)
	Sharing experiences (n=3)	3	0	You can share your problems and get some support. (W4, A)
	Companionship (n=1)	0	1	They provide a place to talk and offer companionship. (M6, WA)
Inclusivity (n=9)	Value-based (n=4)	3	1	A community organisation that is open to diversity would make it much easier for people to engage, it's good to have that ability to talk to someone that completely understands from where I'm coming from and what are the taboos in my culture. (W8, A)
	Interest-based (n=3)	2	1	They provide opportunity to share my passions and interests, because then I could feel that I'm with like-minded people and I'm doing something I love so I can forget about everything else what's going on in my life. (W10, WA)
	Overcome isolation (n=2)	1	1	They make sure people are included, that they are not isolated. (M6, WA)

* WA – without associations with COs, ** A – with associations with COs

W - worker, M - manager

Table 3 *Summary of Workers' Underlying Beliefs*

Themes	Subthemes	Workers with associations (A)	Workers without associations (WA)	Representative quotes
BEHAVIOURAL BELIEFS				
Advantages				
Accessibility (n=13)	Acceptability (n=7)	4	3	There is that kind of feeling that if I walked within a community organisation and something happened to me, that I'd be looked after. (W4, A).
	Approachability (n=6)	2	4	It's like talking with a friend, while when I seek professional assistance, that would be clinical, sterile, impersonal and probably an isolating experience. (W8, A)
Understanding (n=8)	Hearing peers' lived experiences of work-related mental injury (n=5)	3	2	It's about the people who have been through challenges providing advice to others that puts things in perspective, that makes it really special. (W1, WA)
	Sharing of lived experience with peers (n=3)	3	0	I think they are supportive for your mental health, because you can share your problems and get some support. And in that way you don't feel like you're alone with your problem. (W4, A)
Objectivity (n=5)	Unbiased advice (n=3)	2	1	They are neutral, so because of that I would respond well to them. (W17, A)
	An independent perspective (n=2)	2	0	Being external, they are independent from the workplace and therefore more supportive for your mental health. So you can have a conversation with someone who's trusted in that space without wondering if your boss is telling someone else that just creates anxiety. (W4, A)
Disadvantages				
Lack of legitimacy (n=7)	Issues surrounding leadership (n=4)	4	0	If the person behind the organisation is not trusted, if there are problems with the organisation, then people won't trust them. (W7, A)
	Concerns regarding governance (n=3)	2	1	It's making sure that the organisation doesn't come with too much baggage, that there are proper checks in place. (W17, A)
Lack of suitability (n=6)		2	4	There would be a little bit of an education piece on why they were doing it, because my first thought would be to think of Beyond Blue or ones that specialise in mental health. (W17, A)
NORMATIVE BELIEFS				
Approve				
Family (n=7)		4	3	My family, they supported me a few years ago when I needed some time off work. (W2, WA)
Friends (n=5)		4	1	I have a network of trusted, old friends that would be supportive. (W4, A)
Disapprove				
Line manager (n=6)		1	5	When I'm expressing to my boss that I'm stressed and give him cues about my mental health and invite him to have a conversation with me so that we could actually work out what we could do together to make the situation more manageable, he absolutely ignored my cues. So I'm not going to talk to him about my anxiety levels and about seeking help because I know it will fall on deaf ears. (W5, WA)
Work colleagues (n=5)		1	4	I wouldn't talk about this in the workplace with my colleagues because I know that is a career limiting move. (W15, WA)
CONTROL BELIEFS				
Facilitators				
Third-party endorsement (n=7)	Recommendations from government bodies (n=3)	0	3	A neutral, objective agency could be useful as an intermediary to vouch for them. I think some community service announcement from government would be a good way to do this. (W3, WA)
	Recommendations from appropriately qualified organisations (n=2)	2	0	Organisations that employ practitioners are better fitted to provide specialist support or link to community groups that provide mental health information and advice. (W9. A)
	Affiliations with peak bodies (n=2)	2	0	Something like Neighbourhood Houses or CWA have the established credentials to be able to sort of support and validate that a little bit. (W4, A)
Barriers				
Limited access (n=10)	Time limitations (n=6)	4	2	It's great to have all the community support available but if you don't really have the time in your life to actually make that effort…people in our industry don't have this option. (W13, WA)
	Distance constraints (n=4)	2	2	There're still challenges related to geographical distance. Maybe there is a good thing that comes out during this COVID-19 is to normalise video participation in wellbeing activities. (W5, WA).
Lack of skills, training and lived experiences of coordinators/facilitators (n=5)	Unqualified (n=3)	1	2	It's become more obvious with COVID-19 that people are really not supportive of speakers that give statements and health advice without proper credentials. Because they could actually do worse for people. (W4, A)
	Not attracted to celebrity (n=2)	0	2	Celebrity status of a speaker is not a drawing card for me. If you're coming in as if you're a powerhouse, you'll lose your audience. (W1, WA)

WA – without associations with COs, A – with associations with COs, W - worker, M - manager

DISCUSSION

The aims of the current study were to explore the potential benefit of COs to deliver work-related mental health literacy programs from worker and manager perspectives, and to identify worker motivations that might influence intentions to participate in such programs[53,65]. Overall, managers and workers believed that COs had the potential to be a viable, and appealing, alternative to workplace-based programs. Prior or current associations with COs had an impact on workers' perceptions of the advantages and challenges of such an approach. First, findings are discussed in relation to the features of COs as suitable providers of programs, followed by each of the TPB underlying belief categories of workers (behavioural, normative, and control).

Attributes of Community Organisations

Workers and managers believed that using COs to provide mental health literacy programs could potentially overcome some of the barriers to accessing mental health support within workplaces. **Empathy** (n=13) was the most reported attribute which entailed two sub-themes being person-centred (n=8), and caring (n=5). Personalised affective responses to individuals' experiences, feelings and situations[66] have been shown to increase their willingness to seek help[67]. Next was **safety** (n=12) in terms of being outside of workplace setting (n=6), confidential (n=5), and positive (n=1), which could help to overcome some workplace barriers such as fear of discrimination or repercussion on career[12,15]. **Relatability** (n=12) was reported next. This referred to COs being a non-clinical and less stigmatising setting (n=8) and including people to which participants could relate (n=4). This implies COs provide psychologically safe, judgement free, and less intimidating environments that could facilitate worker engagement and help-seeking[68]. **Trustworthiness** (n=11) was the fourth attribute reported as COs are independent from workplaces (n=5) and are unbiased by organisational goals (n=6). This feature may overcome concerns about discrimination and marginalisation associated with help-seeking at work[12,15,34], and supports prior research findings relating to COs' position of trust in the community[17]. **Social support** (n=9), reflected in social connection (n=5), sharing experiences (n=3), and companionship (n=1), and **inclusivity** (n=9), divided into value-based (n=4), interest-based (n=3), and overcoming isolation (n=2), were reported as positive attributes of COs. These results suggest that workers and managers perceive that COs possess a range of attributes that position them favourably to support community efforts to improve the mental health literacy of workers. Next, we explore the underlying motivations of workers to use such opportunities.

The Theory of Planned Behaviour

Behavioural Beliefs

Accessibility to programs is seen as a key advantage by both worker categories (n=13). This supports prior research findings into the role of community-centred approaches in improving access and use of health-related services[69,70]. Two sub-themes, consistent with Levesque's dimensions of service accessibility[71], were acceptability (n=7) and approachability (n=6). Acceptability is the extent to which workers considered programs delivered by COs to be appropriate to their needs[72]. Approachability indicates that workers identified that such a service can be reached and could have a positive impact on their mental health literacy[71]. These two dimensions are critical success factors for initiatives designed to provide health-related services such as work-related mental health literacy programs[71,73,74].

The next advantage of the proposed programs reported was **understanding** (n=8). Understanding had 2 sub-themes which were hearing peers' lived experiences of work-related mental injury (5) and sharing of lived experiences with peers (n=3). Hearing the experiences of peers and being able to share experiences with them serves to provide hope[75,76], alleviate stress and uncertainty[77], de-stigmatise mental injury[78], reduce fear and feelings of isolation[79], and is an important step in encouraging disclosure and help-seeking[80]. None of the workers without previous or current associations reported the sharing of lived experience as an advantage. This suggests that they are not familiar with some of the peer-to-peer benefits of COs and by extension programs offered by them. Strategies emphasising the benefits of engaging with peers that have similar experiences through these programs may improve workers' awareness, and motivation to participate.

The third advantage reported was **objectivity** (n=5), understood in terms of unbiased advice (n=3), and an independent perspective (n=2). Unbiased and independent advice and information serve to alleviate some of the barriers associated with workplace-based programs and contexts, such as concerns about fear, stigmatisation, judgement, and privacy that have been linked to worker reluctance to use workplace counselling services[81–84]. None of the workers without associations with COs identified an independent perspective as an advantage. Communication promoting this, as well as the unbiased nature of programs delivered by COs may enhance participation.

The **lack of legitimacy** (n=7) was the most reported disadvantage. This theme included leadership (n=4), and governance (n=3). Most workers that indicated these concerns had previous or current associations with COs which may reflect some challenges associated with organisations that rely heavily on untrained volunteerism. Screening for organisations that are appropriately structured, led, and governed to deliver these programs is important as worker choices to participate may depend on the perceived quality of leadership and governance of COs. The **lack of suitability** (n=6) was another disadvantage. COs are highly diverse regarding reputation, mission, size, resources[17] and therefore, only organisations that are appropriately positioned should be selected to provide these programs.

Normative Beliefs

Family (n=7) and **friends** (n=5) were reported as the social referents (important others) most likely to approve participation in programs offered by COs for both categories of workers. In contrast, **line managers** (n=6) and **co-workers** (n=5) were believed to likely disapprove, particularly by workers without associations (n=9). Research has shown that organisational culture and social norms strongly impact workers' disclosure and help-seeking behaviours[38,39,85–87]. This suggests that for workers without associations, direct managers continue to be important social referents while workers with prior or current associations were less influenced by the opinions of those within their workplace. Associations with COs present a strong social network which may weaken the reliance on the approval of workplace referents when considering help-seeking and strengthen their potential in delivering mental health literacy programs to promote help-seeking. Messages promoting supervisor and colleague support for CO-delivered mental health literacy programs could potentially help in improving worker participation rates, particularly for those without previous associations with COs.

Control Beliefs

Third-party endorsement (n=7) was reported as a key facilitator to participation, but the type of entity deemed appropriate to provide such endorsement differed between the categories of workers. Workers with associations

with COs preferred recommendations from appropriately qualified organisations (n=2) and peak bodies (n=2), which suggests that they understood the benefit of such affiliations to enhance targeted outcomes. Peak bodies (i.e., Neighbourhood Houses Victoria), have the trust, reputation, resources[88], reach[17], and collaborative experience[89] required to coordinate the implementation of such programs and, therefore, could be useful in helping promote them more widely. Workers without associations referred to endorsement from government entities (n=3), which implies they were not aware of the benefit of affiliations and highlights the importance of having endorsements to fit audience expectations. What this does point to is the importance and potential of cross-sector collaborations with third parties such as government/statutory entities, organisations with work-related mental health expertise, peak bodies and COs, to promote, resource, facilitate, and enhance worker participation.

Limited access (n=10) encompassing time (n=6), and distance (n=4) constraints, was the most identified barrier for workers. Selecting and promoting COs that have the capacity to overcome these limitations through size, reach, delivery models (online and/or outside working hours) could potentially enhance worker participation rates. Another barrier identified was **lack of skills, training and lived experiences of coordinators/facilitators** (n=5). Workers preferred facilitators that were qualified through training or experience to address work-related mental health literacy (n=3). Just relying on the celebrity status of a facilitator, without appropriate skills or experiences was identified as deterrent (n=2). Literature shows that formally trained facilitators, and evidence-based content are critical to ensure program effectiveness[21,28,34]. None of the workers with associations with COs reported the celebrity status of a facilitator/speaker as a barrier. These workers may have been exposed to initiatives that have used people of note and, therefore, were not sceptical of their potential contribution. Research has shown that motivational talks given by notable speakers such as sportsmen have had a positive impact in the community in raising awareness of mental health, particularly on men's intentions to seek help[90]. Our findings indicate that the lived experience of work-related mental illness of a speaker could play a bigger role than their celebrity status in encouraging worker participation, particularly for those that did not have associations with COs. Promotion of programs/events delivered by qualified (skills and experience) coordinators/facilitators may alleviate some of the participation barriers.

Strengths and Limitations

This is the first TPB-based qualitative research that has explored the potential utility of CO-delivered mental health literacy programs to overcome workplace barriers to help-seeking for work-related mental injury. Our study identified a range of worker attitudes and beliefs that indicate that COs are potentially a viable and complementary alternative to workplace-based programs for accessing mental health literacy programs and peer support.

The small convenience sample size of our study limits the transferability of findings. Response bias may be an issue due to participants being self-selecting and may be more motivated by goodwill than the average member of the population. Further, respondents were white-collar workers from large organisations located in a metropolitan area and may have different perspectives than those from smaller blue-collar organisations, or those located in remote/regional settings. Finally, this study was conducted during a global pandemic, which

may have affected respondents' views surrounding mental health approaches within their workplace or wider community.

Future Research

Future research needs to identify COs that are best suited to deliver work-related mental health literacy programs based on the attributes, positioning, and governance structures that workers find appealing and investigate their appetite, capacity, and willingness to provide these programs through cross-sector collaborations. Research needs to explore the benefit of affiliations with relevant, and well-established bodies (i.e., peak bodies) and third-party endorsement of these initiatives via collaborative approaches for effective reach in the community. Future studies could replicate this study using a larger sample that is more representative of workers in general.

CONCLUSION

The current study used a well-founded psychological decision-making theory (TPB) to explore the motivation of workers to engage with mental health literacy programs delivered by COs. Workers with and without current or previous associations with COs were compared. Results showed that COs can provide workers with an alternative to workplace settings to access mental health literacy programs. COs are seen as being suitable as they are empathetic, safe, relatable, trustworthy, supportive, and inclusive environments. Advantages of programs delivered by COs were discussing shared experiences with peers and the opportunity to receive independent perspectives and unbiased advice. Workers without associations with COs were not as aware of these benefits. Family and friends were most likely to approve of participating in such programs. Supervisors and colleagues were important social referents that might disapprove, therefore their support for these programs should be encouraged and communicated. Workers with associations with COs reported the lack of suitability and the legitimacy of leadership and governance of COs as limiting factors. COs that are appropriately structured, led, and governed should be identified to deliver these programs. Workers without associations referred to endorsement by government bodies whereas those with associations referred to endorsement by peak bodies and specialist organisations. Strategic alliances with appropriately positioned COs and third parties such as statutory entities, peak bodies, and organisations with work-related mental health literacy expertise should be explored to inform the development of a framework for cross-sector collaboration to support and promote mental health literacy programs delivered by COs.

Author affiliations

1 Corina Crisan, https://orcid.org/0000-0003-4186-0114
Monash Sustainable Development Institute, Monash University, Melbourne, Victoria, Australia

2 Pieter Andrew Van Dijk, ORCID: https://orcid.org/0000-0002-3110-9848
Monash Business School, Monash University, Melbourne, Victoria, Australia

3 Jennie Oxley, https://orcid.org/0000-0002-7519-1994
Monash University Accident Research Centre, Monash University, Melbourne, Victoria, Australia

4 Andrea De Silva
School of Public Health and Preventive Medicine, Monash University, Melbourne, Victoria, Australia

Competing interests

The authors declare that they have no competing interests.

Author contributions

CC, PAVD, JO and ADS developed the study idea. CC developed the study design and interview protocol, with PAVD providing theoretical expertise and guidance. CC conducted and transcribed the interviews, and PAVD confirmed accuracy. CC analysed the data, and PAVD and JO provided qualitative methods expertise on data analysis and data interpretation. CC drafted the manuscript with regular input from PAVD and JO. PAVD and JO reviewed the draft manuscript. All authors critically reviewed and approved the final version of the manuscript.

Funding

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Patient consent for publication

Not required.

Ethics approval

Ethical approval was obtained from the Monash University Human Research Ethics Committee (MUHREC) (project ID: 20548).

Data sharing statement

No additional data available.

REFERENCES

1 Potter R, O'Keeffe V, Leka S, *et al.* Analytical review of the Australian policy context for work-related psychological health and psychosocial risks. *Saf Sci* 2019;**111**:37–48. doi:10.1016/j.ssci.2018.09.012

2 Cocker F, Sanderson K, LaMontagne AD. Estimating the Economic Benefits of Eliminating Job Strain as a Risk Factor for Depression. *J Occup Environ Med* 2017;**59**:12–7. doi:10.1097/JOM.0000000000000908

3 Harvey SB, Deady M, Wang M-J, *et al.* Is the prevalence of mental illness increasing in Australia? Evidence from national health surveys and administrative data, 2001-2014. *Med J Aust* 2017;**206**:490–3. doi:10.5694/mja16.00295.

4 Productivity Commission. Mental Health. Report no. 95. Canberra, Australia: 2020. https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health.pdf

5 Safe Work Australia. Bullying & Harassment in Australian Workplaces: Results from the Australian Workplace Barometer Project 2014/2015. Canberra, Australia: 2016. doi:10.13140/RG.2.2.11119.43682

6 LaMontagne AD, Keegel T, Vallance D, *et al.* Job strain - Attributable depression in a sample of working Australians: Assessing the contribution to health inequalities. *BMC Public Health* 2008;**8**. doi:10.1186/1471-2458-8-181

7 Harvey SB, Modini M, Joyce S, *et al.* Can work make you mentally ill? A systematic meta-review of work-related risk factors for common mental health problems. *Occup Environ Med* 2017;**74**:301–10. doi:10.1136/oemed-2016-104015.

8 Glozier N. Review of Evidence of Interventions to Reduce Mental Ill-health in the Workplace. Canberra, Australia: 2017.

9 BeyondBlue. State of Workplace Mental Health in Australia. 2014. https://www.headsup.org.au/docs/default-source/resources/bl1270-report---tns-the-state-of-mental-health-in-australian-workplaces-hr.pdf?sfvrsn=8

10 Hanisch SE, Twomey CD, Szeto ACH, *et al.* The effectiveness of interventions targeting the stigma of mental illness at the workplace: a systematic review. *BMC Psychiatry* 2016;**16**:1–11. doi:10.1186/s12888-015-0706-4

11 Dewa CS, Hoch JS. Barriers to Mental Health Service Use among Workers with Depression and Work Productivity. *J Occup Environ Med* 2015;**57**:726–31. doi:10.1097/JOM.0000000000000472

12 Dewa CS, van Weeghel J, Joosen MCW, *et al.* Workers' Decisions to Disclose a Mental Health Issue to Managers and the Consequences. *Front Psychiatry* 2021;**12**:631032. doi:10.3389/fpsyt.2021.631032

13 LaMontagne AD, Milner AJ, Allisey AF, *et al.* An integrated workplace mental health intervention in a policing context: Protocol for a cluster randomised control trial. *BMC Psychiatry* 2016;**16**. doi:10.1186/s12888-016-0741-9

14 Tynan RJ, Considine R, Rich JL, *et al.* Help-seeking for mental health problems by employees in the Australian Mining Industry. *BMC Health Serv Res* 2016;**16**:498. doi:10.1186/s12913-016-1755-1

15 Ammendolia C, Côté P, Cancelliere C, *et al.* Healthy and productive workers: using intervention mapping to design a workplace health promotion and wellness program to improve presenteeism. *BMC Public Health* 2016;**16**:1190. doi:10.1186/s12889-016-3843-x

16 Productivity Commission. Contribution of the Not-for-Profit Sector. Research Report. Canberra, Australia: 2010. https://www.pc.gov.au/inquiries/completed/not-for-profit/report/not-for-profit-report.pdf

17 Lyons A, Fletcher G, Farmer J, *et al.* Participation in rural community groups and links with psychological well-being and resilience: a cross-sectional community-based study. *BMC Psychol* 2016;**4**. doi:10.1186/s40359-016-0121-8

18 Ross AM, Bassilios B. Australian R U OK?Day campaign: Improving helping beliefs, intentions and behaviours. *Int J Ment Health Syst* 2019;**13**. doi:10.1186/s13033-019-0317-4

19 Wilson NJ, Cordier R. A narrative review of Men's Sheds literature: Reducing social isolation and promoting men's health and well-being. *Heal Soc Care Community* 2013;**21**:451–63. doi:10.1111/hsc.12019

20 Jorm AF, Korten AE, Jacomb PA, *et al.* 'Mental health literacy': A survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Med J Aust* 1997;**166**:182–6. doi:10.5694/j.1326-5377.1997.tb140071.x

21 Moll SE, Patten S, Stuart H, *et al.* Beyond Silence: A Randomized, Parallel-Group Trial Exploring the Impact of Workplace Mental Health Literacy Training with Healthcare Employees. *Can J Psychiatry* 2018;**63**:826–833. doi:10.1177/0706743718766051

22 Szeto ACH, Dobson KS. Reducing the stigma of mental disorders at work: A review of current workplace anti-stigma intervention programs. *Appl Prev Psychol* 2010;**14**:41–56. doi:10.1016/j.appsy.2011.11.002

23 Compton RL, McManus JG. Employee Assistance Programs in Australia: Evaluating Success. *J Workplace Behav Health* 2015;**30**:32–45. doi:10.1080/15555240.2015.998971

24 Brouwers EPM, Joosen MCW, van Zelst C, *et al.* To Disclose or Not to Disclose: A Multi-stakeholder Focus Group Study on Mental Health Issues in the Work Environment. *J Occup Rehabil* 2020;**30**:84–92. doi:10.1007/s10926-019-09848-z

25 Hadlaczky G, Hökby S, Mkrtchian A, *et al.* Mental health first aid is an effective public health intervention for improving knowledge, attitudes, and behaviour: A meta-analysis. *Int Rev Psychiatry* 2014;**26**:467–75.

26 Moll S, Patten SB, Stuart H, *et al.* Beyond silence: protocol for a randomized parallel-group trial comparing two approaches to workplace mental health education for healthcare employees. *BMC Med Educ* 2015;**15**. doi:10.1186/s12909-015-0363-9

27 Kelly CM, Jorm AF, Wright A. Improving mental health literacy as a strategy to facilitate early intervention for mental

disorders. *Med J Aust* 2007;**187**:S26–30. doi:10.5694/j.1326-5377.2007.tb01332.x

28 Brijnath B, Protheroe J, Mahtani KR, *et al.* Do Web-based Mental Health Literacy Interventions Improve the Mental Health Literacy of Adult Consumers? Results From a Systematic Review. *J Med Internet Res* 2016;**18**:e165. doi:10.2196/jmir.5463

29 Jorm AF, Christensen H, Griffiths KM. The impact of beyondblue: The national depression initiative on the Australian public's recognition of depression and beliefs about treatments. *Aust N Z J Psychiatry* 2005;**39**:248–54.

30 Bovopoulos N, Jorm AF, Bond KS, *et al.* Providing mental health first aid in the workplace: A Delphi consensus study. *BMC Psychol* 2016;**4**:1–10. doi:10.1186/S40359-016-0148-X/TABLES/4

31 Gulliver A, Griffiths KM, Christensen H, *et al.* A systematic review of help-seeking interventions for depression, anxiety and general psychological distress. *BMC Psychiatry* 2012;**12**. doi:10.1186/1471-244X-12-81

32 Kitchener BA, Jorm AF. Mental health first aid training: Review of evaluation studies. *Aust N Z J Psychiatry* 2006;**40**:6–8. doi:10.1111/j.1440-1614.2006.01735.x

33 Gayed A, Milligan-Saville JS, Nicholas J, *et al.* Effectiveness of training workplace managers to understand and support the mental health needs of employees: A systematic review and meta-analysis. *Occup Environ Med* 2018;**75**:462–70.

34 LaMontagne AD, Martin A, Page KM, *et al.* Workplace mental health: Developing an integrated intervention approach. *BMC Psychiatry* 2014;**14**. doi:10.1186/1471-244X-14-131

35 Reupert A. Enhancing workforce capacity in mental health promotion, prevention and early intervention. *Adv Ment Heal* 2018;**16**:1–4. doi:10.1080/18387357.2018.1429196

36 Reavley NJ, Morgan AJ, Jorm AF. Predictors of experiences of discrimination and positive treatment in people with mental health problems: findings from an Australian national survey. *Soc Psychiatry Psychiatr Epidemiol* 2017;**52**:269–77. doi:10.1007/s00127-016-1301-9

37 Moll SE. The web of silence: A qualitative case study of early intervention and support for healthcare workers with mental ill-health. *BMC Public Health* 2014;**14**. doi:10.1186/1471-2458-14-138

38 Brohan E, Evans-Lacko S, Henderson C, *et al.* Disclosure of a mental health problem in the employment context: Qualitative study of beliefs and experiences. *Epidemiol Psychiatr Sci* 2014;**23**:289–300. doi:10.1017/S2045796013000310

39 Stratton E, Einboden R, Ryan R, *et al.* Deciding to disclose a mental health condition in male dominated workplaces; a focus-group study. *Front Psychiatry* 2018;**9**:1–10. doi:10.3389/fpsyt.2018.00684

40 Harvey SB, Joyce S, Tan L, *et al.* Developing a mentally healthy workplace: A review of the literature. 2014. https://www.headsup.org.au/docs/default-source/resources/developing-a-mentally-healthy-workplace_final-november-2014.pdf?sfvrsn=8

41 Bovopoulos N, Lamontagne AD, Martin A, *et al.* Exploring the role of mental health first aid officers in workplaces. A qualitative study using case study methodology. *Int J Work Heal Manag* 2018;**11**:366-381. doi:10.1108/IJWHM-06-2018-0082

42 Laverack G. Health activism. *Health Promot Int* 2012;**27**:429–34. doi:10.1093/heapro/das044

43 Rossetto A, Potts LC, Reavley NJ, *et al.* Perceptions of positive treatment and discrimination toward people with mental health problems: Findings from the 2017 and 2019 attitudes to mental illness surveys. *Stigma Heal* 2019;**273**:141-148. doi:10.1016/j.psychres.2019.01.027

44 Gardner A, Cotton SM, Allott K, *et al.* Social inclusion and its interrelationships with social cognition and social functioning in first-episode psychosis. *Early Interv Psychiatry* 2019;**13**:477–87. doi:10.1111/eip.12507

45 Filia KM, Jackson HJ, Cotton SM, *et al.* What is social inclusion? A thematic analysis of professional opinion. *Psychiatr Rehabil J* 2018;**41**:183–95. doi:10.1111/eip.12507

46 Syzdek MR, Addis ME, Green JD, *et al.* A pilot trial of gender-based motivational interviewing for help-seeking and internalizing symptoms in men. *Psychol Men Masculinity* 2014;**15**:90–94. doi:10.1037/a0030950

47 Couture SM, Penn DL. Interpersonal contact and the stigma of mental illness: A review of the literature. *J Ment Heal* 2003;**12**:291–305. doi:10.1080/09638231000118276

48 Mead S, Filson B. Mutuality and shared power as an alternative to coercion and force. *Ment Heal Soc Incl* 2017;**21**:144–52. doi:10.1108/MHSI-03-2017-0011

49 Whiteford GE, Pereira RB. Occupation, Inclusion and Participation. In: Whiteford, G. & Hocking C, ed. *Occupational Science: Society, Inclusion, Participation*. Wiley Blackwell 2012. 185–207.

50 Tomczyk S, Schomerus G, Stolzenburg S, *et al.* Ready, Willing and Able? An Investigation of the Theory of Planned Behaviour in Help-Seeking for a Community Sample with Current Untreated Depressive Symptoms. *Prev Sci* 2020;**21**:749–760. doi:10.1007/s11121-020-01099-2

51 White MM, Clough BA, Casey LM. What do help-seeking measures assess? Building a conceptualization framework for help-seeking intentions through a systematic review of measure content. *Clin Psychol Rev* 2018;**59**:61–77. doi:10.1016/j.cpr.2017.11.001

52 Rickwood D, Thomas K. Conceptual measurement framework for help-seeking for mental health problems. *Psychol Res Behav Manag* 2012;**5**:173–183. doi:10.2147/PRBM.S38707

53 Fishbein M, Ajzen I. *Predicting and Changing Behavior: The Reasoned Action Approach (1st ed.)*. NY: Psychology Press 2009. doi:10.4324/9780203838020

54 Ajzen I. The theory of planned behavior. *Organ Behav Hum Decis Process* 1991;**50**:179–211. doi:10.1016/0749-

5978(91)90020-T

55 Ajzen I, Fishbein M. *Understanding Attitudes and Predicting Social Behavior*. Englewood Cliffs, N.J.: Prentice-Hall 1980.

56 O'Brien BC, Harris IB, Beckman TJ, *et al.* Standards for reporting qualitative research: A synthesis of recommendations. *Acad Med* 2014;**89**:1245–51. doi:10.1097/ACM.0000000000000388

57 O'Sullivan D, Rahamathulla M, Pawar M. The Impact and Implications of COVID-19: An Australian Perspective. *Int J Community Soc Dev* 2020;**2**:134–51. doi:10.1177/2516602620937922

58 Patton MQ. *Qualitative Research and Evaluation Methods: Integrating Theory and Practice (4th ed)*. SAGE Publications: Thousand Oaks, US. 2015.

59 Saumure K, Given LM. Data Saturation. In: Given LM, ed. *The SAGE Encyclopedia of Qualitative Research Methods*. SAGE Publications Inc 2008. 195–6.

60 QSR International Pty Ltd. NVivo qualitative data analysis Software (released in March 2020). 2020.https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

61 Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;**3**:77–101. doi:10.1191/1478088706qp063oa

62 Boyatzis RE. *Transforming qualitative information: thematic analysis and code development*. Thousand Oaks, CA: Sage Publications 1998.

63 Nowell LS, Norris JM, White DE, *et al.* Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *Int J Qual Methods* 2017;**16**. doi:10.1177/1609406917733847

64 Miles MB, Huberman a M. *Qualitative Data Analysis: An expanded sourcebook (2nd ed.)*. Thousand Oaks, CA: Sage Publications. 1994.

65 Hardeman W, Johnston M, Johnston D, *et al.* Application of the theory of planned behaviour in behaviour change interventions: A systematic review. *Psychol Heal* 2002;**17**:123–58. doi:10.1080/08870440290013644a

66 Davis MH. Measuring individual differences in empathy: Evidence for a multidimensional approach. *J Pers Soc Psychol* 1983;**44**:113–26. doi:10.1037/0022-3514.44.1.113

67 Martinez AG. When "They" Become "I": Ascribing Humanity to Mental Illness Influences Treatment-Seeking for Mental/Behavioral Health Conditions. *J Soc Clin Psychol* 2014;**33**:187–206. doi:10.1521/JSCP.2014.33.2.187

68 O'donovan R, Mcauliffe E. A systematic review of factors that enable psychological safety in healthcare teams. *Int J Qual Heal Care* 2020;**32**:240–50. doi:10.1093/INTQHC/MZAA025

69 South J, Bagnall A-M, Stansfield JA, *et al.* An evidence-based framework on community-centred approaches for health: England, UK. *Health Promot Int* 2019;**34**:356–66. doi:10.1093/heapro/dax083.

70 Newbigging K, Mohan J, Rees J, *et al.* Contribution of the voluntary sector to mental health crisis care in England: Protocol for a multimethod study. *BMJ Open* 2017;**7**:e019238.

71 Levesque JF, Harris MF, Russell G. Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *Int J Equity Health* 2013;**12**. doi:https://doi.org/10.1186/1475-9276-12-18

72 Sekhon M, Cartwright M, Francis JJ. Acceptability of healthcare interventions: An overview of reviews and development of a theoretical framework. *BMC Health Serv Res* 2017;**17**:1–13. doi:10.1186/s12913-017-2031-8

73 Saurman E. Improving access: Modifying Penchansky and Thomas's theory of access. *J Heal Serv Res Policy* 2016;**2**:36–39. doi:10.1177/1355819615600001

74 Shengelia B, Murry CJ, Adams OB. Beyond Access and Utilization: Defining and Measuring Health System Coverage. In: Murray CJL ED, ed. *Health systems performance assessment. Debates, Methods and Empiricism*. Geneva: World Health Organization 2003. 221–34.

75 Leamy M, Bird V, Boutillier C Le, *et al.* Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *Br J Psychiatry* 2011;**199**:445–52. doi:10.1192/BJP.BP.110.083733

76 WS Y, N H, A H, *et al.* Igniting and Maintaining Hope: The Voices of People Living with Mental Illness. *Community Ment Health J* 2020;**56**:1044–52. doi:10.1007/S10597-020-00557-Z

77 Townsend SSM, Kim HS, Mesquita B. Are You Feeling What I'm Feeling? Emotional Similarity Buffers Stress. *Soc Psychol Personal Sci* 2014;**5**:526–33. doi:10.1177/1948550613511499

78 Peck CE, Lim MH, Purkiss M, *et al.* Development of a Lived Experience-Based Digital Resource for a Digitally-Assisted Peer Support Program for Young People Experiencing Psychosis. *Front Psychiatry* 2020;:635. doi:10.3389/FPSYT.2020.00635

79 Honey A, Boydell KM, Coniglio F, *et al.* Lived experience research as a resource for recovery: a mixed methods study. *BMC Psychiatry 2020 201* 2020;**20**:1–13. doi:10.1186/S12888-020-02861-0

80 Taylor J, Jones RM, O'Reilly P, *et al.* The Station Community Mental Health Centre Inc: nurturing and empowering. *Rural Remote Health* 2010;**10**:1–12. doi:10.22605/RRH1411

81 Lingard H, Francis V. The work-life experiences of office and site-based employees in the Australian construction industry. *Constr Manag Econ* 2004;**22**:991–1002.

82 Azzone V, McCann B, Merrick EL, *et al.* Workplace stress, organizational factors and EAP utilization. *J Workplace Behav Health* 2009;**24**:344–56. doi:10.1080/15555240903188380

83 Walton L. Exploration of the attitudes of employees towards the provision of counselling within a profit-making organisation. *Couns Psychother Res* 2003;**3**:65–71. doi:10.1080/14733140312331384658

84 Deyo-Svendsen ME, Palmer KB, Albright JK, *et al.* Provider Approachability: An All-Staff Survey Approach to Creating a Culture of Safety. *J Patient Saf* 2019;**15**:e64–9. doi:10.1097/PTS.0000000000000409

85 Peters E, Spanier K, Radoschewski FM, *et al.* Influence of social support among employees on mental health and work ability—a prospective cohort study in 2013–15. *Eur J Public Health* 2018;**28**:819–23. doi:10.1093/eurpub/cky067

86 Jung H, von Sternberg K, Davis K. The impact of mental health literacy, stigma, and social support on attitudes toward mental health help-seeking. *Int J Ment Health Promot* 2017;**19**:252–67. doi:10.1080/14623730.2017.1345687

87 Joyce T, Hazelton M, McMillan M. Nurses with mental illness: Their workplace experiences. *Int J Ment Health Nurs* 2007;**16**:373–80. doi:10.1111/j.1447-0349.2007.00492.x.

88 Melville R, Rose. The state and community sector peak bodies: theoretical and policy challenges. *Third Sect Rev* 1999;**5**:25–41.

89 Roberts R, Lockett H, Bagnall C, *et al.* Improving the physical health of people living with mental illness in Australia and New Zealand. *Aust J Rural Health* 2018;**26**:354–62. doi:10.1111/ajr.12457

90 Harding C, Fox C. It's Not About "Freudian Couches and Personality Changing Drugs": An Investigation Into Men's Mental Health Help-Seeking Enablers. *Am J Mens Health* 2015;**9**:451–63. doi:10.1177/1557988314550194.

Supplemental Material A

Questionnaire Worker

ATTRIBUTES OF COMMUNITY ORGANISATIONS

- What are your views about community organisations?
- How do you think community organisations can help address work-related mental injury?
- What is it about community organisations that would make them appealing to you as a mental health literacy program provider?

EXPERIENCES WITH COMMUNITY ORGANISATIONS

- What can you tell me about your experiences or involvement with such organisations?

BEHAVIOURAL BELIEFS

- What do you believe to be the advantages of participating in mental health literacy programs delivered by community organisations, should you have any work-related mental health concerns?
- What do you believe to be the disadvantages of participating in these community-based programs?

NORMATIVE BELIEFS

- Which individuals within your personal/social and work networks do you think would approve of you participating in mental health literacy programs delivered by community organisations, should you have any work-related mental health concerns?
- Which individuals would disapprove of you participating in these community-based programs?

CONTROL BELIEFS

- What would make it easier for you to participate in mental health literacy programs delivered by community organisations to address work-related mental health concerns?
- What would prevent you from participating in these community-based programs?

Supplemental Material B

Questionnaire Manager

ATTRIBUTES OF COMMUNITY ORGANISATIONS

- What are your views about community organisations?
- How do you think community organisations can help address work-related mental injury?
- What is it about community organisations that would make them appealing to you as a mental health literacy program provider?
- Would you be supportive of a community-based approach to work-related mental injury prevention? Why?

EXPERIENCES WITH COMMUNITY ORGANISATIONS

- What can you tell me about your experiences or involvement with such organisations?

Standards for Reporting Qualitative Research (SRQR) - Checklist

No.	Topic	Item	Page
Title and abstract			
S1	Title	Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	1
S2	Abstract	Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	2
Introduction			
S3	Problem formulation	Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	4 - 5
S4	Purpose or research question	Purpose of the study and specific objectives or questions	5
Methods			
S5	Qualitative approach and research paradigm	Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/interpretivist) is also recommended; rationale	5 - 6
S6	Researcher characteristics and reflexivity	Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	7 - 8
S7	Context	Setting/site and salient contextual factors; rationale	6
S8	Sampling strategy	How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale	6 - 7
S9	Ethical issues pertaining to human subjects	Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	7
S10	Data collection methods	Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale	6
S11	Data collection instruments and technologies	Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	6 – 7, 16 – 17: Supplemental material
S12	Units of study	Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	7, Table 1
S13	Data processing	Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/deidentification of excerpts	7 - 8
S14	Data analysis	Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale	7 - 8
S15	Techniques to enhance trustworthiness	Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale	8
Results/findings			
S16	Synthesis and interpretation	Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	8

No.	Topic	Item	Page
S17	Links to empirical data	Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	9 - 10 Tables 2 and 3
Discussion			
S18	Integration with prior work, implications, transferability, and contribution(s) to the field	Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	11 - 14
S19	Limitations	Trustworthiness and limitations of finding	13
Other			
S20	Conflicts of interest	Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	15
S21	Funding	Sources of funding and other support; role of funders in data collection, interpretation, and reporting	15

Reference:

O'Brien BC, Harris IB, Beckman TJ, *et al.* Standards for reporting qualitative research: A synthesis of recommendations. *Acad Med* 2014;**89**:1245–51. doi:10.1097/ACM.0000000000000388

BMJ Open

Worker and manager perceptions of the utility of work-related mental health literacy programs delivered by community organisations: a qualitative study based on the theory of planned behaviour

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2021-056472.R2
Article Type:	Original research
Date Submitted by the Author:	17-Feb-2022
Complete List of Authors:	Crisan, Corina; Monash University, Monash Sustainable Development Institute Van Dijk, Pieter; Monash University, Monash Business School Oxley, Jennie; Monash University, Monash University Accident Research Centre De Silva, Andrea; Monash University, School of Public Health and Preventive Medicine
Primary Subject Heading:	Mental health
Secondary Subject Heading:	Public health, Qualitative research
Keywords:	MENTAL HEALTH, Health policy < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Health & safety < HEALTH SERVICES ADMINISTRATION & MANAGEMENT

I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our licence.

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which Creative Commons licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

TITLE

Worker and manager perceptions of the utility of work-related mental health literacy programs delivered by community organisations: a qualitative study based on the theory of planned behaviour

1 Corina Crisan

2 Pieter Andrew Van Dijk

3 Jennie Oxley

4 Andrea De Silva

Corresponding author

Correspondence to Corina Crisan, email: corina.crisan@monash.edu, mobile: +61 466688138

Word count:

4,440

Keywords

mental injury, workers, managers, help-seeking, mental health literacy, community-based approach, community organisations, Theory of Planned Behaviour, underlying beliefs

ABSTRACT

Objectives

Reluctance to seek help is a leading contributor to escalating mental injury rates in Australian workplaces. We explored the benefit of using community organisations to deliver mental health literacy programs to overcome workplace barriers to help-seeking behaviours.

Design

This study used a qualitative application of The Theory of Planned Behaviour to examine underlying beliefs that may influence worker's intentions to participate in mental health literacy programs delivered by community organisations, and manager support for them.

Setting

This study took place within three large white-collar organisations in the Australian state of Victoria.

Participants

Eighteen workers and eleven managers (n=29) were interviewed to explore perspectives of the benefits of such an approach.

Results

Community organisations have six attributes that make them suitable as an alternative mental health literacy program provider including empathy, safety, relatability, trustworthiness, social support, and inclusivity. Behavioural beliefs included accessibility, understanding, and objectivity. The lack of suitability and legitimacy due to poor governance and leadership were disadvantages. Normative beliefs were that family and friends would most likely approve, while line managers and colleagues were viewed as most likely to disapprove. Control beliefs indicated that endorsements from relevant bodies were facilitators of participation. Distance/time constraints, and the lack of skills, training and lived experiences of coordinators/facilitators were seen as barriers.

Conclusions

Identifying workers' beliefs and perceptions of community organisations has significant implication for the development of effective community-based strategies to improve worker mental health literacy, and help-seeking. Organisations with formal governance structures, and allied with government, peak bodies and work-related mental health organisations would be most suitable. Approaches should focus on lived experience and be delivered by qualified facilitators. Promoting supervisor and colleague support could improve participation. Models to guide cross-sector collaborations to equip community organisations to deliver work-related mental health literacy programs need to be explored.

ARTICLE SUMMARY

Strengths and limitations of this study

- This is the first study that used a qualitative framework to explore worker and manager perceptions of the benefit of using community organisations to deliver mental health literacy programs to support the prevention of, and recovery from work-related mental injury.
- Understanding the underlying beliefs influencing workers' participation in mental health literacy programs delivered by community organisations using a psychological theory-based decision-making model (Theory of Planned Behaviour), is critical for the development of effective strategies to improve engagement rates.
- The small sample size may limit the transferability of findings.

INTRODUCTION

Reluctance to seek help is a leading contributor for escalating mental injury rates in Australian workplaces[1–3]. The financial cost of work-related mental injuries to Australian workplaces is significant, estimated to be more than $12 billion per year in lost productivity[4]. Work-related mental injuries are associated with work-related factors such as job demand and pressure, harassment, bullying, exposure to violence or traumatic events, and interpersonal conflict[5–7]. Many workers are reluctant to use the mental health programs and support mechanisms provided by their workplace[8,9]. Attitudinal barriers to help-seeking include stigma, unrecognized need for help, preference for self-reliance, and belief that treatment would be ineffective[10,11]. Workplace barriers include mistrust of embedded programs such as Employee Assistant Programs, fear of discrimination or repercussion on their career, limited confidence in managers' capabilities surrounding disclosure, and unsupportive organisational cultural norms[12–15]. Furthermore, structural barriers such as the unavailability of service providers outside working hours can also affect access to care[11].

The escalating work-related mental injury rates[4] warrant exploration of alternative ways to reach workers who may be unwilling, or unable, to access organisational and public health support before their mental health concerns reach unhealthy levels. Currently under-explored is the utility of community organisations (COs) to deliver work-related mental health literacy programs designed to address barriers to help-seeking behaviours. These organisations are non-governmental, not-for-profit, that operate for social purposes[16], are accessible and trusted sources of support, and have reach into many sections of the community[17]. COs, such as sporting clubs, Men's Sheds and Neighbourhood Houses, currently provide support for people within the community for a broad range of mental health problems through literacy training and guest speaker events that are designed to destigmatise mental illness and encourage help-seeking, but do not directly address work-related mental health and worker-specific needs[17–19]. A community-based approach using COs to deliver mental health literacy programs could conceivably be more appealing and effective than organisational initiatives.

Mental health literacy refers to knowledge about mental illness and the skills required to recognise, manage, and/or prevent it[20]. The lack of mental health literacy is a key barrier to help-seeking of workers[21,22]. Building workers' capacity/capability to recognise the symptoms of mental injury and access professional support is critical for addressing workplace-induced mental ill-health[11,23,24]. Many programs such as such as Mental Health First Aid (MHFA)[25] promote prevention, self-management and help-seeking for mental ill-health. These interventions often use people with a lived experience of mental injury[26,27] and can take a variety of forms ranging from general awareness events (R U OK?Day)[18] through to structured programs, training modules, and information sessions[21] over the course of multiple hours or days. MHFA training has been effective in reducing mental health stigma, and improving participants' knowledge, attitudes, skills, and confidence to seek professional help[10,20,25,28–32]. Building on evidence of their effectiveness, many employers have implemented mental health literacy programs[8,21,30,33,34] and use these initiatives to promote pathways and referrals to professional services offered by workplaces or public health practitioners[35]. Though these efforts have increased literacy levels of workers[24,36], evidence suggests this has not resulted in supportive attitudes or behaviours in the workplace[37] and therefore low disclosure rates in workplaces are still a problem in addressing work-related mental injuries[9,38].

Previous studies have demonstrated that supportive social referents can be beneficial in the help-seeking process[8,39]. An encouraging environment will facilitate workers' confidence, and the development of tools required to seek timely access to mental health treatment[37]. A supportive workplace management culture exhibiting positive attitudes toward mental health can facilitate workers' willingness to disclose mental health problems[40]. Evidence suggests however that support in many workplaces is insufficient to overcome worker reluctance to seek help. For example, a study has shown that perceptions of bias, role conflict, and hierarchical relationships between the help provider and recipient significantly impact disclosure rates[41]. Importantly, a perceived lack of genuine care and support can contribute to a worker's exclusion, leaving them feeling isolated[37,42,43]. The limitations of current approaches point to the need to explore solutions that can provide the level of support required to encourage workers' help-seeking behaviours.

Such an opportunity may exist in adopting a more socially inclusive approach at a community level[44,45]. A strength of a community-based approach is the practical advice provided by peers with lived experience with no perceived inequality in the power relationship. This has been found to significantly improve participants' recognition of emotional problems, confidence, and coping skills[46–48]. In the context of work-related mental injury, this could involve providing work-focused programs tailored to worker needs delivered outside of workplace settings. As COs have a large reach and are an integral part of the Australian social fabric, they are well-placed to be a vehicle to reach disadvantaged and isolated workers by providing tailored opportunities to access mental health literacy programs to overcome barriers to help-seeking[49]. What needs to be determined is if such an approach has any appeal or perceived benefit.

Theory of Planned Behaviour

To address the identified gaps in the literature, this study applied the Theory of Planned Behaviour (TPB), a theory-based and robust decision-making model that is the most applied framework to better understand decision-making and behaviour change[50–54]. The TPB posits that intention to perform a behaviour is primarily guided by three constructs. These are attitude (overall evaluation of participation), subjective norms (perceived social pressure associated with participation), and perceived behavioural control (the perceived degree of ease or difficulty to participate). Each of these constructs are influenced by the associated underlying beliefs, including behavioural beliefs (advantages and disadvantages of participation), normative beliefs (key referents who approve or disapprove of such participation), and control beliefs (barriers or facilitators to participation). The TPB is used in this study as an evidence-based framework for examining key beliefs influencing worker attitudes and intentions toward making use of the proposed CO-delivery of mental health literacy programs. A key strength of the TPB is that it facilitates identification of beliefs that differentiate users and non-users[55], which can help in the development of targeted strategies to facilitate decision making/behaviour change[53].

The Current Study

The objective of this study is to determine the potential utility of using COs to deliver work-related mental health literacy programs to help overcome workplace barriers to help-seeking. The two aims associated with this objective are (1) to explore attributes of COs that make them suitable to deliver work-related mental health literacy programs from the perspective of workers (as a potential user) and managers (as an important social referent), and (2) to examine the motivations that influence worker intentions to potentially participate in such programs, including how prior or current associations with COs may influence these motivations.

To the authors' knowledge, no previous studies have used the TPB to explore the factors influencing workers' potential participation in CO-delivered mental health literacy programs, or to explore perceptions of a key social referent group (managers) toward such an approach. It is anticipated that the results of this study will inform opportunities for cross-sector collaborations to promote and enhance worker participation in mental health literacy programs delivered by COs for the prevention of, and recovery from work-related mental injury.

METHODS

Guidelines developed by O'Brien, Harris, Beckman et al (2014) were followed to ensure the transparency of reporting on research design and methods of data collection and analysis[56].

Procedure

CEOs or HR/OHS Managers from twenty-seven large organisations (with 200+ workers) in the Australian state of Victoria with comprehensive mental health programs in place were contacted by email with an invitation to participate in the study. The information included that the purpose of the interviews was to explore perceptions of workers and managers within the organisation about the potential utility of mental health literacy programs delivered by COs to address barriers to help-seeking for work-related mental injury. The invitation established that no mental health assessment would be conducted, participation was anonymous, voluntary, and information collected would be confidential. No reimbursements were provided. Out of twenty-seven organisations, nine initially responded (33%) however only three workplaces finally participated (11%) due to challenges related to COVID-19. The information flyer and consent form were distributed through formal organisational communication channels, as approved by the Monash University Human Research Ethics Committee (project ID: 20548). Selection criteria for workers included any full or part-time staff in a permanent or contracted role and who had been employed with the organisation for at least 6 months. Managers were invited based on their level of seniority within the organisation (executive or senior managers) and/or expertise in HR/OHS (convenience sample). The first author contacted respondents who expressed interest to confirm their eligibility. Informed consent was obtained from all participants prior to data collection.

The interviews were conducted via video platforms (Zoom/Microsoft Teams) due to COVID-19 physical distancing restrictions at the time of data collection[57]. The purpose of the research was explained, and demographic information was collected. Participants were informed that they could withdraw from the study at any time. Established interview protocols and techniques were followed to minimise interviewer and response bias[58]. Twenty-nine interviews were conducted over a four-month period between January and April 2020. Interviews were audio-recorded (average duration 46 minutes). Field notes were made following each interview to document the interviewer's impressions and ensure reflexivity[58]. Data collection ceased at the point of data saturation[59]. The transcriptions were stored on a password-protected computer to which only the first two authors had access.

Materials

At the beginning of each interview, participants were provided with a definition of mental health literacy. We described current CO initiatives that provide mental health literacy programs addressing general mental health awareness. In addition to general questions exploring managers' and workers' views of, and workers' prior or

current associations with COs, a belief elicitation interview protocol was used to explore workers' underlying beliefs about using mental health literacy programs delivered by COs (see supplemental material A). Interviews included open-ended questions and a conversational style to allow in-depth examination of participants' perceptions and experiences[58]. To explore underlying behavioural beliefs, workers were asked about advantages and disadvantages of attending these programs if the need arose. Normative beliefs were identified through questions about the role of significant people within their social and work networks in their decision to participate in these programs. Control beliefs were explored through questions focusing on what made it easier or more difficult for workers to participate, and what encouraged or prevented them from using such opportunities. Probing questions were used when needed to clarify the responses, gain further insights, and overcome researcher bias[48]. Managers with HR/OHS experience were interviewed to understand how mental health literacy programs delivered by COs might be perceived and supported in workplaces. Particularly, to understand whether they believed such approaches would complement existing workplace-based programs, and/or overcome some of the perceived access barriers associated with these programs (see supplemental material B). The interview protocols were piloted with three workers and two managers from the research team's professional network and subsequently refined prior to commencing data collection. This data was excluded from the analysis.

Participants

Participants (n=29; 16 female, 13 male) of which eighteen workers and eleven managers were aged 29–64 years. Eighteen participants worked in the public sector and eleven in the private sector. Nineteen participants were employed in an ongoing role, with the remainder in a contracting role. Participants were also classified as 'With Associations' (A) or 'Without Associations' (WA) depending on whether they had prior or current associations with COs or not. Table 1 shows the key demographic details of participants.

Table 1 *Demographic Characteristics of Study Participants*

		Workers; n (%)	Managers; n (%)
Associations with COs	With associations (prior/current)	9 (50%)	5 (45.5%)
	Without associations	9 (50%)	6 (54.5%)
Gender	Female	11 (61.1%)	5 (45.5%)
	Male	7 (38.9%)	6 (54.5%)
Age	25-34	1 (5.6%)	0 (0%)
	35-44	5 (27.8%)	5 (45.5%)
	45-54	6 (33.3%)	3 (27.2%)
	55-64	6 (33.3%)	3 (27.2%)
Employment Tenure	Permanent	13 (72.2%)	6 (54.5%)
	Contracted	5 (27.8%)	5 (45.5%)
Industry	Public sector	12 (66.6%)	6 (54.5%)
	Private sector	6 (33.4%)	5 (45.5%)

Patient and Public Involvement

This study involved no patients, only members of the public who were in active employment. No patients or public were involved in the design, recruitment to, or conduct of this study. The results have not been disseminated to the study participants. However, each participant was provided with an information sheet containing the Monash University website that will publish the findings of the study and the research team's contact details, should they wish to be directly informed of the study's results.

Data Analysis

All interview responses were transcribed verbatim by the first author, then confirmed for accuracy by the second author and imported into NVivo 12 software[60]. Each interview transcript was deidentified and assigned a unique code (W-worker, M-manager). Braun & Clarke's six-stage thematic approach (familiarisation with the data, coding, searching for themes from the codes, reviewing themes, defining and naming themes, and writing up the themes)[61] was used to identify and interpret patterns within data. Data analysis was both inductively and deductively compared to the TPB framework[62].

The first author coded responses of a subset of interview transcripts (n=5) using the TPB framework and constructs (behavioural beliefs, normative beliefs, and control beliefs). Field notes that were written following each interview were subsequently used in data analysis discussions among research team members to overcome any potential biases[58]. The initial codes were checked for emerging patterns and grouped into a draft framework of themes that were semantically close to the participants' wording[63]. Where applicable, themes were further split into sub-themes. The validity of these themes and sub-themes was checked by the second and third authors who have expertise in qualitative methods. It was determined that they were relevant to the research questions and representative of the data[61]. The framework was then applied to the remaining transcripts, whilst allowing for emergent themes until no new themes could be determined[64].

As the fieldwork and data analysis progressed, transcripts were reviewed systematically by the team's qualitative experts, and themes were refined iteratively based on recurrence and their relationship to each other. Any differences of opinion were discussed until consensus was reached among the research team. Once themes and sub-themes were confirmed, data was explored to identify common themes and understand the relationship between them[61]. Inter-rater reliability reached 90 per cent agreement[64].

RESULTS

Table 2 summarises workers' and managers' views about the attributes of COs that make them suitable for providing work-related mental health literacy programs with supporting quotes. Empathy, safety, relatability, trustworthiness, social support, and inclusivity were reported as appealing attributes of COs. Table 3 summarises the findings by the TPB belief categories. These are further divided by workers with associations with COs and those without, with supporting quotes. For the behavioural beliefs, the most reported advantages of participation in programs delivered by COs included accessibility (acceptability and approachability), understanding (hearing peers' lived experiences of work-related mental injury and sharing of lived experience with peers), and objectivity (unbiased by organisational goals and independent from workplaces). None of the

workers without associations reported sharing of lived experience with peers, and being independent from workplaces as advantages. The lack of legitimacy (leadership and governance), and lack of suitability were reported as disadvantages. No worker without associations mentioned issues surrounding leadership. For the normative beliefs, family and friends were reported as the social referents most likely to approve, while line managers and co-workers were viewed as most likely to disapprove of such participation. For the control beliefs, third-party endorsement was the most reported facilitator. Affiliations with peak organisations, or those with work-related mental health expertise were reported by workers with prior or current associations with COs. Those without associations reported endorsement by government bodies. Limited access (distance and time constraints), and the lack of skills, training and lived experiences of coordinators/facilitators (unqualified, celebrity) were the commonly reported barriers.

Table 2 *Attributes of Community Organisations*

Themes	Sub-themes	Workers n= 18	Managers n = 11	Representative Quotes
Empathy (n=13)	Person-centred (n=8)	4	4	Community organisations are so good at looking after the person and delivering a person-centric service. (M4, WA*)
	Caring (n=5)	4	1	Those people, especially if they are members of community groups like CWA, are more empathetic. Those group members are there to be part of a social group and to participate in society. They are not fly fishing by themselves or looking for some rich boys' club reasons to participate. (W4, A**)
Safety (n=12)	Outside of workplace setting (n=6)	3	3	One of the things that would be appealing to seek community-based support for mental health issues is that it's separate from your workplace. (M3, A)
	Confidential (n=5)	2	3	It's about having that confidence that what's said in the room stays in the room. (W1, WA)
	Positive (n=1)	1	0	Something like a men's shed that has a really positive kind of vibe, a positive atmosphere and it's safe, that would be good. (W17, A)
Relatability (n=12)	Non-clinical and less stigmatising setting (n=8)	4	4	I think these organisations could help make mental health something that people talk about more freely because they've got less stigma about it, so you don't feel like there's something wrong with you as when you go to a professional. (W10, WA)
	Including people to which participants could relate (n=4)	3	1	Having an organisation with people that actually have lived experience that can be advocates of reaching out to people with similar issues, who can actually explain 'this is how I went through it', it's important. (W13, WA)
Trustworthiness (n=11)	Unbiased by organisational goals (n=6)	2	4	Having someone who's not biased, who is not invested either way, who can sit back, and listen in a way that's not judgmental, getting them to tell their story, to open up. I think in the workplace it's difficult to achieve that. (M6, WA)
	Independent from workplaces (n=5)	3	2	They are independent, and that's what makes their message so powerful. It goes back to trust and that's where the community organisations fit in. (W17, A)
Social support (n=9)	Social connection (n=5)	4	1	If you really struggle with work, or something awful is going on there, you know that you've got another thing that supports you. (W9, A)
	Sharing experiences (n=3)	3	0	You can share your problems and get some support. (W4, A)
	Companionship (n=1)	0	1	They provide a place to talk and offer companionship. (M6, WA)
Inclusivity (n=9)	Value-based (n=4)	3	1	A community organisation that is open to diversity would make it much easier for people to engage, it's good to have that ability to talk to someone that completely understands where I'm coming from and what are the taboos in my culture. (W8, A)
	Interest-based (n=3)	2	1	They provide opportunity to share my passions and interests, because then I could feel that I'm with like-minded people and I'm doing something I love so I can forget about everything else that's going on in my life. (W10, WA)
	Overcome isolation (n=2)	1	1	They make sure people are included, that they are not isolated. (M6, WA)

* WA – without associations with COs, ** A – with associations with COs

W - worker, M - manager

Table 3 *Summary of Workers' Underlying Beliefs*

Themes	Subthemes	Workers with associations (A)	Workers without associations (WA)	Representative quotes
BEHAVIOURAL BELIEFS				
Advantages				
Accessibility (n=13)	Acceptability (n=7)	4	3	There is that kind of feeling that if I walked within a community organisation and something happened to me, that I'd be looked after. (W4, A).
	Approachability (n=6)	2	4	It's like talking with a friend, while when I seek professional assistance, that would be clinical, sterile, impersonal and probably an isolating experience. (W8, A)
Understanding (n=8)	Hearing peers' lived experiences of work-related mental injury (n=5)	3	2	It's about the people who have been through challenges providing advice to others that puts things in perspective, that makes it really special. (W1, WA)
	Sharing of lived experience with peers (n=3)	3	0	I think they are supportive of your mental health, because you can share your problems and get some support. And in that way you don't feel like you're alone with your problem. (W4, A)
Objectivity (n=5)	Unbiased advice (n=3)	2	1	They are neutral, so because of that I would respond well to them. (W17, A)
	An independent perspective (n=2)	2	0	Being external, they are independent from the workplace and therefore more supportive for your mental health. So you can have a conversation with someone who's trusted in that space without wondering if your boss is telling someone else that just creates anxiety. (W4, A)
Disadvantages				
Lack of legitimacy (n=7)	Issues surrounding leadership (n=4)	4	0	If the person behind the organisation is not trusted, if there are problems with the organisation, then people won't trust them. (W7, A)
	Concerns regarding governance (n=3)	2	1	It's making sure that the organisation doesn't come with too much baggage, that there are proper checks in place. (W17, A)
Lack of suitability (n=6)		2	4	There would be a little bit of an education piece on why they were doing it, because my first thought would be to think of Beyond Blue or ones that specialise in mental health. (W17, A)
NORMATIVE BELIEFS				
Approve				
Family (n=7)		4	3	My family, they supported me a few years ago when I needed some time off work. (W2, WA)
Friends (n=5)		4	1	I have a network of trusted, old friends that would be supportive. (W4, A)
Disapprove				
Line manager (n=6)		1	5	When I'm expressing to my boss that I'm stressed and give him cues about my mental health and invite him to have a conversation with me so that we could actually work out what we could do together to make the situation more manageable, he absolutely ignored my cues. So I'm not going to talk to him about my anxiety levels and about seeking help because I know it will fall on deaf ears. (W5, WA)
Work colleagues (n=5)		1	4	I wouldn't talk about this in the workplace with my colleagues because I know that is a career limiting move. (W15, WA)
CONTROL BELIEFS				
Facilitators				
Third-party endorsement (n=7)	Recommendations from government bodies (n=3)	0	3	A neutral, objective agency could be useful as an intermediary to vouch for them. I think some community service announcement from the government would be a good way to do this. (W2, WA)
	Recommendations from appropriately qualified organisations (n=2)	2	0	Organisations that employ practitioners are better fitted to provide specialist support or link to community groups that provide mental health information and advice. (W9. A)
	Affiliations with peak bodies (n=2)	2	0	Something like Neighbourhood Houses or CWA have the established credentials to be able to sort of support and validate that a little bit. (W4, A)
Barriers				
Limited access (n=10)	Time limitations (n=6)	4	2	It's great to have all the community support available but if you don't really have the time in your life to actually make that effort…people in our industry don't have this option. (W13, WA)
	Distance constraints (n=4)	2	2	There're still challenges related to geographical distance. Maybe there is a good thing that comes out during this COVID-19 is to normalise video participation in wellbeing activities. (W5, WA).
Lack of skills, training and lived experiences of coordinators/facilitators (n=5)	Unqualified (n=3)	1	2	It's become more obvious with COVID-19 that people are really not supportive of speakers that give statements and health advice without proper credentials. Because they could actually do worse for people. (W4, A)
	Not attracted to celebrity (n=2)	0	2	Celebrity status of a speaker is not a drawing card for me. If you're coming in as if you're a powerhouse, you'll lose your audience. (W1, WA)

WA – without associations with COs, A – with associations with COs, W - worker, M - manager

DISCUSSION

The aims of the current study were to explore the potential benefit of COs to deliver work-related mental health literacy programs from worker and manager perspectives, and to identify worker motivations that might influence intentions to participate in such programs[53,65]. Overall, managers and workers believed that COs had the potential to be a viable, and appealing, alternative to workplace-based programs. Prior or current associations with COs had an impact on workers' perceptions of the advantages and challenges of such an approach. First, findings are discussed in relation to the features of COs as suitable providers of programs, followed by each of the TPB underlying belief categories of workers (behavioural, normative, and control).

Attributes of Community Organisations

Workers and managers believed that using COs to provide mental health literacy programs could potentially overcome some of the barriers to accessing mental health support within workplaces. **Empathy** (n=13) was the most reported attribute which entailed two sub-themes being person-centred (n=8), and caring (n=5). Personalised affective responses to individuals' experiences, feelings and situations[66] have been shown to increase their willingness to seek help[67]. Next was **safety** (n=12) in terms of being outside of workplace setting (n=6), confidential (n=5), and positive (n=1), which could help to overcome some workplace barriers such as fear of discrimination or repercussion on career[12,15]. **Relatability** (n=12) was reported next. This referred to COs being a non-clinical and less stigmatising setting (n=8) and including people to which participants could relate (n=4). This implies COs provide psychologically safe, judgement free, and less intimidating environments that could facilitate worker engagement and help-seeking[68]. **Trustworthiness** (n=11) was the fourth attribute reported as COs are independent from workplaces (n=5) and are unbiased by organisational goals (n=6). This feature may overcome concerns about discrimination and marginalisation associated with help-seeking at work[12,15,34], and supports prior research findings relating to COs' position of trust in the community[17]. **Social support** (n=9), reflected in social connection (n=5), sharing experiences (n=3), and companionship (n=1), and **inclusivity** (n=9), divided into value-based (n=4), interest-based (n=3), and overcoming isolation (n=2), were reported as positive attributes of COs. These results suggest that workers and managers perceive that COs possess a range of attributes that position them favourably to support community efforts to improve the mental health literacy of workers. Next, we explore the underlying motivations of workers to use such opportunities.

The Theory of Planned Behaviour

Behavioural Beliefs

Accessibility to programs is seen as a key advantage by both worker categories (n=13). This supports prior research findings into the role of community-centred approaches in improving access and use of health-related services[69,70]. Two sub-themes, consistent with Levesque's dimensions of service accessibility[71], were acceptability (n=7) and approachability (n=6). Acceptability is the extent to which workers considered programs delivered by COs to be appropriate to their needs[72]. Approachability indicates that workers identified that such a service can be reached and could have a positive impact on their mental health literacy[71]. These two dimensions are critical success factors for initiatives designed to provide health-related services such as work-related mental health literacy programs[71,73,74].

The next advantage of the proposed programs reported was **understanding** (n=8). Understanding had 2 sub-themes which were hearing peers' lived experiences of work-related mental injury (5) and sharing of lived experiences with peers (n=3). Hearing the experiences of peers and being able to share experiences with them serves to provide hope[75,76], alleviate stress and uncertainty[77], de-stigmatise mental injury[78], reduce fear and feelings of isolation[79], and is an important step in encouraging disclosure and help-seeking[80]. None of the workers without previous or current associations reported the sharing of lived experience as an advantage. This suggests that they are not familiar with some of the peer-to-peer benefits of COs and by extension programs offered by them. Strategies emphasising the benefits of engaging with peers that have similar experiences through these programs may improve workers' awareness, and motivation to participate.

The third advantage reported was **objectivity** (n=5), understood in terms of unbiased advice (n=3), and an independent perspective (n=2). Unbiased and independent advice and information serve to alleviate some of the barriers associated with workplace-based programs and contexts, such as concerns about fear, stigmatisation, judgement, and privacy that have been linked to worker reluctance to use workplace counselling services[81–84]. None of the workers without associations with COs identified an independent perspective as an advantage. Communication promoting this, as well as the unbiased nature of programs delivered by COs may enhance participation.

The **lack of legitimacy** (n=7) was the most reported disadvantage. This theme included leadership (n=4), and governance (n=3). Most workers that indicated these concerns had previous or current associations with COs which may reflect some challenges associated with organisations that rely heavily on untrained volunteerism. Screening for organisations that are appropriately structured, led, and governed to deliver these programs is important as worker choices to participate may depend on the perceived quality of leadership and governance of COs. The **lack of suitability** (n=6) was another disadvantage. COs are highly diverse regarding reputation, mission, size, resources[17] and therefore, only organisations that are appropriately positioned should be selected to provide these programs.

Normative Beliefs

Family (n=7) and **friends** (n=5) were reported as the social referents (important others) most likely to approve participation in programs offered by COs for both categories of workers. In contrast, **line managers** (n=6) and **co-workers** (n=5) were believed to likely disapprove, particularly by workers without associations (n=9). Research has shown that organisational culture and social norms strongly impact workers' disclosure and help-seeking behaviours[38,39,85–87]. This suggests that for workers without associations, direct managers continue to be important social referents while workers with prior or current associations were less influenced by the opinions of those within their workplace. Associations with COs present a strong social network which may weaken the reliance on the approval of workplace referents when considering help-seeking and strengthen their potential in delivering mental health literacy programs to promote help-seeking. Messages promoting supervisor and colleague support for CO-delivered mental health literacy programs could potentially help in improving worker participation rates, particularly for those without previous associations with COs.

Control Beliefs

Third-party endorsement (n=7) was reported as a key facilitator to participation, but the type of entity deemed appropriate to provide such endorsement differed between the categories of workers. Workers with associations

with COs preferred recommendations from appropriately qualified organisations (n=2) and peak bodies (n=2), which suggests that they understood the benefit of such affiliations to enhance targeted outcomes. Peak bodies (i.e., Neighbourhood Houses Victoria), have the trust, reputation, resources[88], reach[17], and collaborative experience[89] required to coordinate the implementation of such programs and, therefore, could be useful in helping promote them more widely. Workers without associations referred to endorsement from government entities (n=3), which implies they were not aware of the benefit of affiliations and highlights the importance of having endorsements to fit audience expectations. What this does point to is the importance and potential of cross-sector collaborations with third parties such as government/statutory entities, organisations with work-related mental health expertise, peak bodies and COs, to promote, resource, facilitate, and enhance worker participation.

Limited access (n=10) encompassing time (n=6), and distance (n=4) constraints, was the most identified barrier for workers. Selecting and promoting COs that have the capacity to overcome these limitations through size, reach, delivery models (online and/or outside working hours) could potentially enhance worker participation rates. Another barrier identified was **lack of skills, training and lived experiences of coordinators/facilitators** (n=5). Workers preferred facilitators that were qualified through training or experience to address work-related mental health literacy (n=3). Just relying on the celebrity status of a facilitator, without appropriate skills or experiences was identified as deterrent (n=2). Literature shows that formally trained facilitators, and evidence-based content are critical to ensure program effectiveness[21,28,34]. None of the workers with associations with COs reported the celebrity status of a facilitator/speaker as a barrier. These workers may have been exposed to initiatives that have used people of note and, therefore, were not sceptical of their potential contribution. Research has shown that motivational talks given by notable speakers such as sportsmen have had a positive impact in the community in raising awareness of mental health, particularly on men's intentions to seek help[90]. Our findings indicate that the lived experience of work-related mental illness of a speaker could play a bigger role than their celebrity status in encouraging worker participation, particularly for those that did not have associations with COs. Promotion of programs/events delivered by qualified (skills and experience) coordinators/facilitators may alleviate some of the participation barriers.

Strengths and Limitations

This is the first TPB-based qualitative research that has explored the potential utility of CO-delivered mental health literacy programs to overcome workplace barriers to help-seeking for work-related mental injury. Our study identified a range of worker attitudes and beliefs that indicate that COs are potentially a viable and complementary alternative to workplace-based programs for accessing mental health literacy programs and peer support.

The small convenience sample size of our study limits the transferability of findings. Response bias may be an issue due to participants being self-selecting and may be more motivated by goodwill than the average member of the population. Further, respondents were white-collar workers from large organisations located in a metropolitan area and may have different perspectives than those from smaller blue-collar organisations, or those located in remote/regional settings. Finally, this study was conducted during a global pandemic, which

may have affected respondents' views surrounding mental health approaches within their workplace or wider community.

Future Research

Future research needs to identify COs that are best suited to deliver work-related mental health literacy programs based on the attributes, positioning, and governance structures that workers find appealing and investigate their appetite, capacity, and willingness to provide these programs through cross-sector collaborations. Research needs to explore the benefit of affiliations with relevant, and well-established bodies (i.e., peak bodies) and third-party endorsement of these initiatives via collaborative approaches for effective reach in the community. Future studies could replicate this study using a larger sample that is more representative of workers in general.

CONCLUSION

The current study used a well-founded psychological decision-making theory (TPB) to explore the motivation of workers to engage with mental health literacy programs delivered by COs. Workers with and without current or previous associations with COs were compared. Results showed that COs can provide workers with an alternative to workplace settings to access mental health literacy programs. COs are seen as being suitable as they are empathetic, safe, relatable, trustworthy, supportive, and inclusive environments. Advantages of programs delivered by COs were discussing shared experiences with peers and the opportunity to receive independent perspectives and unbiased advice. Workers without associations with COs were not as aware of these benefits. Family and friends were most likely to approve of participating in such programs. Supervisors and colleagues were important social referents that might disapprove, therefore their support for these programs should be encouraged and communicated. Workers with associations with COs reported the lack of suitability and the legitimacy of leadership and governance of COs as limiting factors. COs that are appropriately structured, led, and governed should be identified to deliver these programs. Workers without associations referred to endorsement by government bodies whereas those with associations referred to endorsement by peak bodies and specialist organisations. Strategic alliances with appropriately positioned COs and third parties such as statutory entities, peak bodies, and organisations with work-related mental health literacy expertise should be explored to inform the development of a framework for cross-sector collaboration to support and promote mental health literacy programs delivered by COs.

Author affiliations

1 Corina Crisan, https://orcid.org/0000-0003-4186-0114
Monash Sustainable Development Institute, Monash University, Melbourne, Victoria, Australia

2 Pieter Andrew Van Dijk, ORCID: https://orcid.org/0000-0002-3110-9848
Monash Business School, Monash University, Melbourne, Victoria, Australia

3 Jennie Oxley, https://orcid.org/0000-0002-7519-1994
Monash University Accident Research Centre, Monash University, Melbourne, Victoria, Australia

4 Andrea De Silva
School of Public Health and Preventive Medicine, Monash University, Melbourne, Victoria, Australia

Competing interests

The authors declare that they have no competing interests.

Author contributions

CC, PAVD, JO and ADS developed the study idea. CC developed the study design and interview protocol, with PAVD providing theoretical expertise and guidance. CC conducted and transcribed the interviews, and PAVD confirmed accuracy. CC analysed the data, and PAVD and JO provided qualitative methods expertise on data analysis and data interpretation. CC drafted the manuscript with regular input from PAVD and JO. PAVD and JO reviewed the draft manuscript. All authors critically reviewed and approved the final version of the manuscript.

Funding

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Patient consent for publication

Not required.

Ethics approval

Ethical approval was obtained from the Monash University Human Research Ethics Committee (MUHREC) (project ID: 20548).

Data sharing statement

No additional data available.

REFERENCES

1 Potter R, O'Keeffe V, Leka S, *et al.* Analytical review of the Australian policy context for work-related psychological health and psychosocial risks. *Saf Sci* 2019;**111**:37–48. doi:10.1016/j.ssci.2018.09.012

2 Cocker F, Sanderson K, LaMontagne AD. Estimating the Economic Benefits of Eliminating Job Strain as a Risk Factor for Depression. *J Occup Environ Med* 2017;**59**:12–7. doi:10.1097/JOM.0000000000000908

3 Harvey SB, Deady M, Wang M-J, *et al.* Is the prevalence of mental illness increasing in Australia? Evidence from national health surveys and administrative data, 2001-2014. *Med J Aust* 2017;**206**:490–3. doi:10.5694/mja16.00295.

4 Productivity Commission. Mental Health. Report no. 95. Canberra, Australia: 2020. https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health.pdf

5 Safe Work Australia. Bullying & Harassment in Australian Workplaces: Results from the Australian Workplace Barometer Project 2014/2015. Canberra, Australia: 2016. doi:10.13140/RG.2.2.11119.43682

6 LaMontagne AD, Keegel T, Vallance D, *et al.* Job strain - Attributable depression in a sample of working Australians: Assessing the contribution to health inequalities. *BMC Public Health* 2008;**8**. doi:10.1186/1471-2458-8-181

7 Harvey SB, Modini M, Joyce S, *et al.* Can work make you mentally ill? A systematic meta-review of work-related risk factors for common mental health problems. *Occup Environ Med* 2017;**74**:301–10. doi:10.1136/oemed-2016-104015.

8 Glozier N. Review of Evidence of Interventions to Reduce Mental Ill-health in the Workplace. Canberra, Australia: 2017.

9 BeyondBlue. State of Workplace Mental Health in Australia. 2014. https://www.headsup.org.au/docs/default-source/resources/bl1270-report---tns-the-state-of-mental-health-in-australian-workplaces-hr.pdf?sfvrsn=8

10 Hanisch SE, Twomey CD, Szeto ACH, *et al.* The effectiveness of interventions targeting the stigma of mental illness at the workplace: a systematic review. *BMC Psychiatry* 2016;**16**:1–11. doi:10.1186/s12888-015-0706-4

11 Dewa CS, Hoch JS. Barriers to Mental Health Service Use among Workers with Depression and Work Productivity. *J Occup Environ Med* 2015;**57**:726–31. doi:10.1097/JOM.0000000000000472

12 Dewa CS, van Weeghel J, Joosen MCW, *et al.* Workers' Decisions to Disclose a Mental Health Issue to Managers and the Consequences. *Front Psychiatry* 2021;**12**:631032. doi:10.3389/fpsyt.2021.631032

13 LaMontagne AD, Milner AJ, Allisey AF, *et al.* An integrated workplace mental health intervention in a policing context: Protocol for a cluster randomised control trial. *BMC Psychiatry* 2016;**16**. doi:10.1186/s12888-016-0741-9

14 Tynan RJ, Considine R, Rich JL, *et al.* Help-seeking for mental health problems by employees in the Australian Mining Industry. *BMC Health Serv Res* 2016;**16**:498. doi:10.1186/s12913-016-1755-1

15 Ammendolia C, Côté P, Cancelliere C, *et al.* Healthy and productive workers: using intervention mapping to design a workplace health promotion and wellness program to improve presenteeism. *BMC Public Health* 2016;**16**:1190. doi:10.1186/s12889-016-3843-x

16 Productivity Commission. Contribution of the Not-for-Profit Sector. Research Report. Canberra, Australia: 2010. https://www.pc.gov.au/inquiries/completed/not-for-profit/report/not-for-profit-report.pdf

17 Lyons A, Fletcher G, Farmer J, *et al.* Participation in rural community groups and links with psychological well-being and resilience: a cross-sectional community-based study. *BMC Psychol* 2016;**4**. doi:10.1186/s40359-016-0121-8

18 Ross AM, Bassilios B. Australian R U OK?Day campaign: Improving helping beliefs, intentions and behaviours. *Int J Ment Health Syst* 2019;**13**. doi:10.1186/s13033-019-0317-4

19 Wilson NJ, Cordier R. A narrative review of Men's Sheds literature: Reducing social isolation and promoting men's health and well-being. *Heal Soc Care Community* 2013;**21**:451–63. doi:10.1111/hsc.12019

20 Jorm AF, Korten AE, Jacomb PA, *et al.* 'Mental health literacy': A survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Med J Aust* 1997;**166**:182–6. doi:10.5694/j.1326-5377.1997.tb140071.x

21 Moll SE, Patten S, Stuart H, *et al.* Beyond Silence: A Randomized, Parallel-Group Trial Exploring the Impact of Workplace Mental Health Literacy Training with Healthcare Employees. *Can J Psychiatry* 2018;**63**:826–833. doi:10.1177/0706743718766051

22 Szeto ACH, Dobson KS. Reducing the stigma of mental disorders at work: A review of current workplace anti-stigma intervention programs. *Appl Prev Psychol* 2010;**14**:41–56. doi:10.1016/j.appsy.2011.11.002

23 Compton RL, McManus JG. Employee Assistance Programs in Australia: Evaluating Success. *J Workplace Behav Health* 2015;**30**:32–45. doi:10.1080/15555240.2015.998971

24 Brouwers EPM, Joosen MCW, van Zelst C, *et al.* To Disclose or Not to Disclose: A Multi-stakeholder Focus Group Study on Mental Health Issues in the Work Environment. *J Occup Rehabil* 2020;**30**:84–92. doi:10.1007/s10926-019-09848-z

25 Hadlaczky G, Hökby S, Mkrtchian A, *et al.* Mental health first aid is an effective public health intervention for improving knowledge, attitudes, and behaviour: A meta-analysis. *Int Rev Psychiatry* 2014;**26**:467–75.

26 Moll S, Patten SB, Stuart H, *et al.* Beyond silence: protocol for a randomized parallel-group trial comparing two approaches to workplace mental health education for healthcare employees. *BMC Med Educ* 2015;**15**. doi:10.1186/s12909-015-0363-9

27 Kelly CM, Jorm AF, Wright A. Improving mental health literacy as a strategy to facilitate early intervention for mental

disorders. *Med J Aust* 2007;**187**:S26–30. doi:10.5694/j.1326-5377.2007.tb01332.x

28 Brijnath B, Protheroe J, Mahtani KR, *et al.* Do Web-based Mental Health Literacy Interventions Improve the Mental Health Literacy of Adult Consumers? Results From a Systematic Review. *J Med Internet Res* 2016;**18**:e165. doi:10.2196/jmir.5463

29 Jorm AF, Christensen H, Griffiths KM. The impact of beyondblue: The national depression initiative on the Australian public's recognition of depression and beliefs about treatments. *Aust N Z J Psychiatry* 2005;**39**:248–54.

30 Bovopoulos N, Jorm AF, Bond KS, *et al.* Providing mental health first aid in the workplace: A Delphi consensus study. *BMC Psychol* 2016;**4**:1–10. doi:10.1186/S40359-016-0148-X/TABLES/4

31 Gulliver A, Griffiths KM, Christensen H, *et al.* A systematic review of help-seeking interventions for depression, anxiety and general psychological distress. *BMC Psychiatry* 2012;**12**. doi:10.1186/1471-244X-12-81

32 Kitchener BA, Jorm AF. Mental health first aid training: Review of evaluation studies. *Aust N Z J Psychiatry* 2006;**40**:6–8. doi:10.1111/j.1440-1614.2006.01735.x

33 Gayed A, Milligan-Saville JS, Nicholas J, *et al.* Effectiveness of training workplace managers to understand and support the mental health needs of employees: A systematic review and meta-analysis. *Occup Environ Med* 2018;**75**:462–70.

34 LaMontagne AD, Martin A, Page KM, *et al.* Workplace mental health: Developing an integrated intervention approach. *BMC Psychiatry* 2014;**14**. doi:10.1186/1471-244X-14-131

35 Reupert A. Enhancing workforce capacity in mental health promotion, prevention and early intervention. *Adv Ment Heal* 2018;**16**:1–4. doi:10.1080/18387357.2018.1429196

36 Reavley NJ, Morgan AJ, Jorm AF. Predictors of experiences of discrimination and positive treatment in people with mental health problems: findings from an Australian national survey. *Soc Psychiatry Psychiatr Epidemiol* 2017;**52**:269–77. doi:10.1007/s00127-016-1301-9

37 Moll SE. The web of silence: A qualitative case study of early intervention and support for healthcare workers with mental ill-health. *BMC Public Health* 2014;**14**. doi:10.1186/1471-2458-14-138

38 Brohan E, Evans-Lacko S, Henderson C, *et al.* Disclosure of a mental health problem in the employment context: Qualitative study of beliefs and experiences. *Epidemiol Psychiatr Sci* 2014;**23**:289–300. doi:10.1017/S2045796013000310

39 Stratton E, Einboden R, Ryan R, *et al.* Deciding to disclose a mental health condition in male dominated workplaces; a focus-group study. *Front Psychiatry* 2018;**9**:1–10. doi:10.3389/fpsyt.2018.00684

40 Harvey SB, Joyce S, Tan L, *et al.* Developing a mentally healthy workplace: A review of the literature. 2014. https://www.headsup.org.au/docs/default-source/resources/developing-a-mentally-healthy-workplace_final-november-2014.pdf?sfvrsn=8

41 Bovopoulos N, Lamontagne AD, Martin A, *et al.* Exploring the role of mental health first aid officers in workplaces. A qualitative study using case study methodology. *Int J Work Heal Manag* 2018;**11**:366-381. doi:10.1108/IJWHM-06-2018-0082

42 Laverack G. Health activism. *Health Promot Int* 2012;**27**:429–34. doi:10.1093/heapro/das044

43 Rossetto A, Potts LC, Reavley NJ, *et al.* Perceptions of positive treatment and discrimination toward people with mental health problems: Findings from the 2017 and 2019 attitudes to mental illness surveys. *Stigma Heal* 2019;**273**:141-148. doi:10.1016/j.psychres.2019.01.027

44 Gardner A, Cotton SM, Allott K, *et al.* Social inclusion and its interrelationships with social cognition and social functioning in first-episode psychosis. *Early Interv Psychiatry* 2019;**13**:477–87. doi:10.1111/eip.12507

45 Filia KM, Jackson HJ, Cotton SM, *et al.* What is social inclusion? A thematic analysis of professional opinion. *Psychiatr Rehabil J* 2018;**41**:183–95. doi:10.1111/eip.12507

46 Syzdek MR, Addis ME, Green JD, *et al.* A pilot trial of gender-based motivational interviewing for help-seeking and internalizing symptoms in men. *Psychol Men Masculinity* 2014;**15**:90–94. doi:10.1037/a0030950

47 Couture SM, Penn DL. Interpersonal contact and the stigma of mental illness: A review of the literature. *J Ment Heal* 2003;**12**:291–305. doi:10.1080/09638231000118276

48 Mead S, Filson B. Mutuality and shared power as an alternative to coercion and force. *Ment Heal Soc Incl* 2017;**21**:144–52. doi:10.1108/MHSI-03-2017-0011

49 Whiteford GE, Pereira RB. Occupation, Inclusion and Participation. In: Whiteford, G. & Hocking C, ed. *Occupational Science: Society, Inclusion, Participation*. Wiley Blackwell 2012. 185–207.

50 Tomczyk S, Schomerus G, Stolzenburg S, *et al.* Ready, Willing and Able? An Investigation of the Theory of Planned Behaviour in Help-Seeking for a Community Sample with Current Untreated Depressive Symptoms. *Prev Sci* 2020;**21**:749–760. doi:10.1007/s11121-020-01099-2

51 White MM, Clough BA, Casey LM. What do help-seeking measures assess? Building a conceptualization framework for help-seeking intentions through a systematic review of measure content. *Clin Psychol Rev* 2018;**59**:61–77. doi:10.1016/j.cpr.2017.11.001

52 Rickwood D, Thomas K. Conceptual measurement framework for help-seeking for mental health problems. *Psychol Res Behav Manag* 2012;**5**:173–183. doi:10.2147/PRBM.S38707

53 Fishbein M, Ajzen I. *Predicting and Changing Behavior: The Reasoned Action Approach (1st ed.)*. NY: Psychology Press 2009. doi:10.4324/9780203838020

54 Ajzen I. The theory of planned behavior. *Organ Behav Hum Decis Process* 1991;**50**:179–211. doi:10.1016/0749-

5978(91)90020-T

55 Ajzen I, Fishbein M. *Understanding Attitudes and Predicting Social Behavior*. Englewood Cliffs, N.J.: Prentice-Hall 1980.

56 O'Brien BC, Harris IB, Beckman TJ, *et al.* Standards for reporting qualitative research: A synthesis of recommendations. *Acad Med* 2014;**89**:1245–51. doi:10.1097/ACM.0000000000000388

57 O'Sullivan D, Rahamathulla M, Pawar M. The Impact and Implications of COVID-19: An Australian Perspective. *Int J Community Soc Dev* 2020;**2**:134–51. doi:10.1177/2516602620937922

58 Patton MQ. *Qualitative Research and Evaluation Methods: Integrating Theory and Practice (4th ed)*. SAGE Publications: Thousand Oaks, US. 2015.

59 Saumure K, Given LM. Data Saturation. In: Given LM, ed. *The SAGE Encyclopedia of Qualitative Research Methods*. SAGE Publications Inc 2008. 195–6.

60 QSR International Pty Ltd. NVivo qualitative data analysis Software (released in March 2020). 2020.https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

61 Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;**3**:77–101. doi:10.1191/1478088706qp063oa

62 Boyatzis RE. *Transforming qualitative information: thematic analysis and code development*. Thousand Oaks, CA: Sage Publications 1998.

63 Nowell LS, Norris JM, White DE, *et al.* Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *Int J Qual Methods* 2017;**16**. doi:10.1177/1609406917733847

64 Miles MB, Huberman a M. *Qualitative Data Analysis: An expanded sourcebook (2nd ed.)*. Thousand Oaks, CA: Sage Publications. 1994.

65 Hardeman W, Johnston M, Johnston D, *et al.* Application of the theory of planned behaviour in behaviour change interventions: A systematic review. *Psychol Heal* 2002;**17**:123–58. doi:10.1080/08870440290013644a

66 Davis MH. Measuring individual differences in empathy: Evidence for a multidimensional approach. *J Pers Soc Psychol* 1983;**44**:113–26. doi:10.1037/0022-3514.44.1.113

67 Martinez AG. When "They" Become "I": Ascribing Humanity to Mental Illness Influences Treatment-Seeking for Mental/Behavioral Health Conditions. *J Soc Clin Psychol* 2014;**33**:187–206. doi:10.1521/JSCP.2014.33.2.187

68 O'donovan R, Mcauliffe E. A systematic review of factors that enable psychological safety in healthcare teams. *Int J Qual Heal Care* 2020;**32**:240–50. doi:10.1093/INTQHC/MZAA025

69 South J, Bagnall A-M, Stansfield JA, *et al.* An evidence-based framework on community-centred approaches for health: England, UK. *Health Promot Int* 2019;**34**:356–66. doi:10.1093/heapro/dax083.

70 Newbigging K, Mohan J, Rees J, *et al.* Contribution of the voluntary sector to mental health crisis care in England: Protocol for a multimethod study. *BMJ Open* 2017;**7**:e019238.

71 Levesque JF, Harris MF, Russell G. Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *Int J Equity Health* 2013;**12**. doi:https://doi.org/10.1186/1475-9276-12-18

72 Sekhon M, Cartwright M, Francis JJ. Acceptability of healthcare interventions: An overview of reviews and development of a theoretical framework. *BMC Health Serv Res* 2017;**17**:1–13. doi:10.1186/s12913-017-2031-8

73 Saurman E. Improving access: Modifying Penchansky and Thomas's theory of access. *J Heal Serv Res Policy* 2016;**2**:36–39. doi:10.1177/1355819615600001

74 Shengelia B, Murry CJ, Adams OB. Beyond Access and Utilization: Defining and Measuring Health System Coverage. In: Murray CJL ED, ed. *Health systems performance assessment. Debates, Methods and Empiricism*. Geneva: World Health Organization 2003. 221–34.

75 Leamy M, Bird V, Boutillier C Le, *et al.* Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *Br J Psychiatry* 2011;**199**:445–52. doi:10.1192/BJP.BP.110.083733

76 WS Y, N H, A H, *et al.* Igniting and Maintaining Hope: The Voices of People Living with Mental Illness. *Community Ment Health J* 2020;**56**:1044–52. doi:10.1007/S10597-020-00557-Z

77 Townsend SSM, Kim HS, Mesquita B. Are You Feeling What I'm Feeling? Emotional Similarity Buffers Stress. *Soc Psychol Personal Sci* 2014;**5**:526–33. doi:10.1177/1948550613511499

78 Peck CE, Lim MH, Purkiss M, *et al.* Development of a Lived Experience-Based Digital Resource for a Digitally-Assisted Peer Support Program for Young People Experiencing Psychosis. *Front Psychiatry* 2020;:635. doi:10.3389/FPSYT.2020.00635

79 Honey A, Boydell KM, Coniglio F, *et al.* Lived experience research as a resource for recovery: a mixed methods study. *BMC Psychiatry 2020 201* 2020;**20**:1–13. doi:10.1186/S12888-020-02861-0

80 Taylor J, Jones RM, O'Reilly P, *et al.* The Station Community Mental Health Centre Inc: nurturing and empowering. *Rural Remote Health* 2010;**10**:1–12. doi:10.22605/RRH1411

81 Lingard H, Francis V. The work-life experiences of office and site-based employees in the Australian construction industry. *Constr Manag Econ* 2004;**22**:991–1002.

82 Azzone V, McCann B, Merrick EL, *et al.* Workplace stress, organizational factors and EAP utilization. *J Workplace Behav Health* 2009;**24**:344–56. doi:10.1080/15555240903188380

83 Walton L. Exploration of the attitudes of employees towards the provision of counselling within a profit-making organisation. *Couns Psychother Res* 2003;**3**:65–71. doi:10.1080/14733140312331384658

84 Deyo-Svendsen ME, Palmer KB, Albright JK, *et al.* Provider Approachability: An All-Staff Survey Approach to Creating a Culture of Safety. *J Patient Saf* 2019;**15**:e64–9. doi:10.1097/PTS.0000000000000409

85 Peters E, Spanier K, Radoschewski FM, *et al.* Influence of social support among employees on mental health and work ability—a prospective cohort study in 2013–15. *Eur J Public Health* 2018;**28**:819–23. doi:10.1093/eurpub/cky067

86 Jung H, von Sternberg K, Davis K. The impact of mental health literacy, stigma, and social support on attitudes toward mental health help-seeking. *Int J Ment Health Promot* 2017;**19**:252–67. doi:10.1080/14623730.2017.1345687

87 Joyce T, Hazelton M, McMillan M. Nurses with mental illness: Their workplace experiences. *Int J Ment Health Nurs* 2007;**16**:373–80. doi:10.1111/j.1447-0349.2007.00492.x.

88 Melville R, Rose. The state and community sector peak bodies: theoretical and policy challenges. *Third Sect Rev* 1999;**5**:25–41.

89 Roberts R, Lockett H, Bagnall C, *et al.* Improving the physical health of people living with mental illness in Australia and New Zealand. *Aust J Rural Health* 2018;**26**:354–62. doi:10.1111/ajr.12457

90 Harding C, Fox C. It's Not About "Freudian Couches and Personality Changing Drugs": An Investigation Into Men's Mental Health Help-Seeking Enablers. *Am J Mens Health* 2015;**9**:451–63. doi:10.1177/1557988314550194.

Supplemental Material A

Questionnaire Worker

ATTRIBUTES OF COMMUNITY ORGANISATIONS

- What are your views about community organisations?
- How do you think community organisations can help address work-related mental injury?
- What is it about community organisations that would make them appealing to you as a mental health literacy program provider?

EXPERIENCES WITH COMMUNITY ORGANISATIONS

- What can you tell me about your experiences or involvement with such organisations?

BEHAVIOURAL BELIEFS

- What do you believe to be the advantages of participating in mental health literacy programs delivered by community organisations, should you have any work-related mental health concerns?
- What do you believe to be the disadvantages of participating in these community-based programs?

NORMATIVE BELIEFS

- Which individuals within your personal/social and work networks do you think would approve of you participating in mental health literacy programs delivered by community organisations, should you have any work-related mental health concerns?
- Which individuals would disapprove of you participating in these community-based programs?

CONTROL BELIEFS

- What would make it easier for you to participate in mental health literacy programs delivered by community organisations to address work-related mental health concerns?
- What would prevent you from participating in these community-based programs?

Supplemental Material B

Questionnaire Manager

ATTRIBUTES OF COMMUNITY ORGANISATIONS

- What are your views about community organisations?
- How do you think community organisations can help address work-related mental injury?
- What is it about community organisations that would make them appealing to you as a mental health literacy program provider?
- Would you be supportive of a community-based approach to work-related mental injury prevention? Why?

EXPERIENCES WITH COMMUNITY ORGANISATIONS

- What can you tell me about your experiences or involvement with such organisations?

Standards for Reporting Qualitative Research (SRQR) - Checklist

No.	Topic	Item	Page
Title and abstract			
S1	Title	Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	1
S2	Abstract	Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	2
Introduction			
S3	Problem formulation	Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	4 - 5
S4	Purpose or research question	Purpose of the study and specific objectives or questions	5 - 6
Methods			
S5	Qualitative approach and research paradigm	Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/interpretivist) is also recommended; rationale	5 - 6
S6	Researcher characteristics and reflexivity	Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	8
S7	Context	Setting/site and salient contextual factors; rationale	6
S8	Sampling strategy	How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale	6 - 7
S9	Ethical issues pertaining to human subjects	Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	7
S10	Data collection methods	Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale	6
S11	Data collection instruments and technologies	Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	6 – 7, Supplemental material A and B
S12	Units of study	Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	7, Table 1
S13	Data processing	Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/deidentification of excerpts	8
S14	Data analysis	Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale	8
S15	Techniques to enhance trustworthiness	Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale	8
Results/findings			
S16	Synthesis and interpretation	Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	8-9

No.	Topic	Item	Page
S17	Links to empirical data	Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	10 - 11 Tables 2 and 3
Discussion			
S18	Integration with prior work, implications, transferability, and contribution(s) to the field	Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	12 - 14
S19	Limitations	Trustworthiness and limitations of finding	14 - 15
Other			
S20	Conflicts of interest	Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	16
S21	Funding	Sources of funding and other support; role of funders in data collection, interpretation, and reporting	16

Reference:

O'Brien BC, Harris IB, Beckman TJ, *et al.* Standards for reporting qualitative research: A synthesis of recommendations. *Acad Med* 2014;**89**:1245–51. doi:10.1097/ACM.0000000000000388