

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

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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 programmes 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 programmes 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 11 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 programme 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 was 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, 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

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 programmes to support the prevention of, and recovery from work-related mental injury.
- Understanding the underlying beliefs influencing workers' participation in mental health literacy programmes 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.

organisations to deliver work-related mental health literacy programmes need to be explored.

INTRODUCTION

Reluctance to seek help is a leading contributor to 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 AUD \$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 programmes and support mechanisms provided by their workplace.⁸⁻⁹ Attitudinal barriers to help seeking include stigma, unrecognised need for help, preference for

self-reliance and belief that treatment would be ineffective.^{10 11} Workplace barriers include mistrust of embedded programmes such as employee assistant programmes, 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 rates⁴ 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, underexplored is the utility of community organisations (COs) to deliver work-related mental health literacy programmes 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 programmes 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 programmes 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 programmes, training modules and information sessions²¹ 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 programmes^{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 that this has not resulted in supportive attitudes or behaviours in the workplace³⁷ 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 towards 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 programmes 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 programmes 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

towards making use of the proposed CO delivery of mental health literacy programmes. 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 programmes 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 programmes 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 programmes, 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 programmes or to explore perceptions of a key social referent group (managers) towards 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 programmes delivered by COs for the prevention of, and recovery from work-related mental injury.

METHODS

Guidelines developed by O'Brien *et al* were followed to ensure the transparency of reporting on research design and methods of data collection and analysis.⁵⁶

Procedure

Chief Executive Officers (CEOs) or Human Resources/Occupational Health and Safety (HR/OHS) managers from 27 large organisations (with 200+ workers) in the Australian state of Victoria with comprehensive mental health programmes 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 programmes 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 27 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. 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 4-month period between January and April 2020. Interviews were audio-recorded (average duration 46 min). 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 programmes 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 programmes delivered by COs (see online 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 programmes 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 programmes. 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 programmes delivered by COs might be perceived and supported in workplaces. Particularly, to understand whether they believed such approaches would complement existing workplace-based

**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)

CO, community organisation.

programmes and/or overcome some of the perceived access barriers associated with these programmes (see online 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. These data were excluded from the analysis.

Participants

Participants (n=29; 16 women, 13 men) of which 18 workers and 11 managers were aged 29–64 years. Eighteen participants worked in the public sector and 11 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.

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 V.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 with 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 subthemes. The validity of these themes and subthemes 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, while 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 subthemes were confirmed, data were explored to identify common themes and understand the relationship between them.⁶¹ Inter-rater reliability reached 90% 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 programmes 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 programmes 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

Table 2 Attributes of community organisations

Themes	Subthemes	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.

CO, community organisation; M, manager; W, worker.

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				

Continued

Table 3 Continued

Themes	Subthemes	Workers with associations (A)	Workers without associations (WA)	Representative quotes
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.
CO, community organisation; M, manager; W, worker.

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 coworkers 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), the lack of skills, training and lived experiences of coordinators/facilitators (unqualified, celebrity) were the commonly reported barriers.

DISCUSSION

The aims of the current study were to explore the potential benefit of COs to deliver work-related mental health literacy programmes from worker and manager perspectives and to identify worker motivations that might influence intentions to participate in such programmes.^{53 65} Overall, managers and workers believed that COs had the potential to be a viable, and appealing, alternative to workplace-based programmes. 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 programmes, followed by each of the TPB underlying belief categories of workers (behavioural, normative and control).

Attributes of COs

Workers and managers believed that using COs to provide mental health literacy programmes 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 subthemes being person-centred (n=8) and caring (n=5). Personalised affective responses to individuals' experiences, feelings and situations⁶⁶ 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 TPB

Behavioural beliefs

Accessibility to programmes 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 subthemes, 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 programmes 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 programmes.^{71 73 74}

The next advantage of the proposed programmes reported was *understanding* (n=8). Understanding had two subthemes, 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 destigmatise mental injury,⁷⁸ reduce fear and feelings of isolation⁷⁹ 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 programmes offered by them. Strategies emphasising the benefits of engaging with peers that have similar experiences through these programmes 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 programmes 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 programmes 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 who 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 programmes 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, resources¹⁷ and, therefore, only organisations that are appropriately positioned should be selected to provide these programmes.

Normative beliefs

Family (n=7) and *friends* (n=5) were reported as the social referents (important others) most likely to approve participation in programmes offered by COs for both categories of workers. In contrast, *line managers* (n=6) and *coworkers* (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 programmes to promote help seeking. Messages promoting supervisor and colleague support for CO-delivered mental health literacy programmes 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 (ie, Neighbourhood Houses Victoria) have the trust, reputation, resources,⁸⁸ reach¹⁷ and collaborative experience⁸⁹ required to coordinate the implementation of such programmes 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 programme 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 who did not have associations with COs. Promotion of programmes/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 programmes 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 programmes for accessing mental health literacy programmes 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. Furthermore, 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 programmes based on the attributes, positioning and governance structures that workers find appealing and



investigate their appetite, capacity and willingness to provide these programmes through cross-sector collaborations. Research needs to explore the benefit of affiliations with relevant, and well-established bodies (ie, 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 programmes 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 programmes. COs are seen as being suitable as they are empathetic, safe, relatable, trustworthy, supportive and inclusive environments. Advantages of programmes 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 programmes. Supervisors and colleagues were important social referents that might disapprove, therefore their support for these programmes 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 who are appropriately structured, led and governed should be identified to deliver these programmes. 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 programmes delivered by COs.

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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.

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