The Impact of Psychosocial Safety Climate on Mental Health Stigma Discrimination and Psychological Health: A Scoping Review

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This report is submitted in partial fulfillment of the degree of Master of Psychology (O&HF)

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Declaration

This dissertation contains no material which has been accepted for the award of any other degree or diploma in any University, and, to the best of my knowledge, contains no materials previously published except where due reference is made. I give permission for the digital version of my dissertation to be made available on the web, via the University's digital research repository, the Library Search and also through web search engines, unless permission has been granted by the School to restrict access for a period of time.

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Statement of Contribution

My supervisor and I generated the idea for the project, which was refined in consultation with my other supervisor. My supervisors assisted with refinement of most parts of the thesis.

Publication

This article is intended for submission to The Journal of Applied Psychology, which adheres to the APA 7 reference style. At present the article has been written to the Master of Psychology (Clinical/Health/Organisational and Human Factors) Research Report requirements of 6,000-8,000 words but will be edited prior to submission to meet the word limit specified by The Journal of Applied Psychology.

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Abstract

Background Ensuring workplaces are psychosocially safe and healthy environments is critical to adhering with Work Health and Safety laws and reducing risk of harm to workers. This scoping review aims to curate evidence to quantify how psychosocial safety climate (PSC) protects workers from the negative psychological impacts of mental health stigma and discrimination (MHSD).

Methods A literature search was conducted across two main databases (PsychExtra and ProQuest). A reference list of eligible studies was also checked for additional papers. Only full-text peer-reviewed articles written in English were eligible for this review.

Results A search in the databases produced 923 records, and through a rigorous screening process, 35 papers were included in this review. Due to the limited literature, PSC was expanded to all psychosocial climates and organisations undertaking activities to improve psychosocial work conditions. Employees reporting high PSC and activities promoting healthy psychosocial work conditions typically reported lower levels of MHSD. Additionally, MHSD was found to increase negative workplace psychological symptoms like burnout. Moreover, the theory and research indicates that PSC interventions foster the conditions (e.g., support) for individuals experiencing MHSD to be protected from developing further negative workplace psychological symptoms.

Conclusion Managers' efforts directed towards creating psychosocially safe workplace climates by prioritising worker wellbeing, designing fair and quality jobs, fostering bottom-up communication through non-discriminatory organisational policies, practices and procedures helps to create high PSC, which in turn, may help to protect workers from the negative symptoms of MHSD.

Research Questions:

RQ1: Are workplace climates promoting high levels of psychosocial health and safety associated with less future MHSD? What psychosocial health and safety interventions are associated with less MHSD in organisations?

RQ2: Is workplace MHSD positively related to reported work-related psychological health symptoms (e.g., burnout)?

Introduction

Mental health stigma and discrimination (MHSD) in the workplace leads to negative outcomes for both the individual (Rüsch et al., 2014) and the organisation (Brohan & Thornicroft, 2010), and is illegal under the Equal Opportunity Act 1984. However, it is still prevalent (Stuart et al., 2014). MHSD is the negative stereotypes, prejudice and discriminatory behaviour towards people with a mental illness (Collins et al., 2012). The Mental Health Foundation conducted a survey to explore experiences at work for employees with mental illnesses. One in ten of those with mental health problems believed that colleagues made snide or sarcastic comments, or avoided them because of their mental health problems. More than 15 per cent believed that they had missed promotion because of their condition. 25 per cent stated they felt more patronised or monitored than other colleagues. Respondents felt that there was still a stigma attached to mental health problems, as only one third felt confident disclosing their ill health on application forms (Mental Health Foundation, 2002). Understanding how climates and psychosocial work conditions might reduce MHSD and moderate the impact of MHSD on further workplace psychological health deterioration is important to address and mitigate perpetuating cycles of harm.

Previous research has examined individual level relationships exploring whether PSC mediates the relationship between stigma and reporting stress-related concerns (Klinefelter et al., 2021), or stigma as a mediator of the PSC and psychological health relationship (DeOrsey, 2020) or help seeking behaviours (Britt et al., 2020). This study makes a unique contribution to the extant literature as it considers how shared perceptions of the climate for psychological health

and safety and/or psychosocial work conditions impact stigma and subsequent psychological health. Shared perceptions develop in organisations because employees seek to organise complex conflicting information by discerning global patterns of expected behaviour (Zohar & Luria, 2005).

Psychosocial Safety Climate (PSC) has been theoretically developed over the past thirteen years determining that the causes of poor psychosocial work conditions and work stress may be multilevel rather than individual in nature requiring attention to the infrastructure and systems of operation to manage psychosocial health and safety in organisations (Zadow et al., 2019). PSC is a specific aspect of organisational climate, defined as "policies, practices, and procedures for worker psychological health and safety" (Dollard et al., 2017). PSC is the work climate that creates psychosocial demands and resources for employees and has been shown to have a stronger impact on future workplace psychological health than psychosocial work conditions such as long working hours (Zadow et al., 2021). Workers reporting high levels of PSC feel that their psychological safety and well-being is protected and supported by senior management (Bond et al., 2010). Growing evidence suggests that PSC predicts workplace stigma and subsequent reporting of stress-related concerns (Klinefelter et al., 2021), or reduces the impact of stigma on psychological health relationship (DeOrsey, 2020) or help seeking behaviours (Britt et al., 2020) requiring a review to curate and quantify these relationships to inform future evidence-based interventions.

Involvement in the workforce can be an important part of recovery for individuals with mental illness (BeyondBlue, 2011). Evidence suggests that individuals with mental illness produce the same quality of work as people without mental illness, however those with mental illness experience bias in selection due to stigma and discrimination (Maximin et al., 2022). In

addition, MHSD has been argued to create greater stress and depression in individuals who are already mentally ill (Malterud et al., 2022). Therefore, such stigma and discrimination are not only standing in the way of recovery for individuals with mental illness, but have potential to also worsen their symptoms.

Diversity and inclusion climates have been linked to workplace stigma and discrimination, but the role of a climate to support psychological health and safety has not been clearly examined. Organisational diversity is the distribution of differences amongst employees in relation to a particular attribute (Harrison & Klein, 2007). Organisational discrimination is denying an employee equal treatment based on their group membership (Triana et al., 2021). Increasing workplace diversity is beneficial to organisations because there are many benefits including; financial performance (Smulowitz et al., 2019), organisational performance (Auh & Menguc, 2006), innovation and patient care (Gomex & Bernet, 2019) and creativity (Hundschell et al., 2022). The research outlines three broad approaches to promote workplace diversity, the first being establishing organisational responsibility for diversity (Kalev et al., 2006). Organisational responsibility for diversity may involve the promotion of climates: e.g., Diversity climate (the degree to which a firm advocates fair HR policies and socially integrates diverse employees) (McKay et al., 2008), Inclusion climate (how strongly employees feel that their unique backgrounds, skills, knowledge and ideas are integrated in a workplace) (Nishii, 2013). The evidence that diversity and inclusion climates have been linked to workplace stigma and discrimination suggests that the same may be true for the role of a climate to support psychological health and safety. Hence, this will be explored in this scoping review.

Psychological Safety Climate

The psychosocial safety climate (PSC) theoretical framework proposes that the system of operation, or the infrastructure within an organisation, advocates for the protection of psychological health and safety. PSC influences the workplace psychosocial job demands and subsequent employee psychological health (Dollard et al., 2019; Dollard & Bakker, 2010). It is proposed that organisations with low PSC lack the policies, practices and procedures to manage psychological health and safety, leading to poorly designed jobs with chronic job demands and subsequent employee psychological health symptoms (a health erosion process) (Loh et al., 2020). Alternatively, PSC has also been shown to moderate the relationship between psychosocial job demands (emotional demands, bullying) reducing the impact on psychological outcomes such as emotional exhaustion and depression by acting as a protective barrier (Dollard et al., 2019).

When employees experience high levels of emotional demands at work, this may deplete the resources of the employee leading to burnout. However, when high levels of PSC are perceived in the form of priority and commitment to psychological health combined with communication and participation practices to articulate and address concerns relating to psychological health, this mitigates the impact of emotional demands on psychological health (Zadow & Dollard, 2016; Zadow et al., 2021). A gap in PSC theory is how the climate for psychological health and safety may influence MHSD and also buffer the impact of MHSD on subsequent psychological health. PSC is a specific aspect of organisational climate, defined as "policies, practices, and procedures for worker psychological health and safety" (Dollard et al., 2017). PSC is largely determined by management and leadership within organisations, and is characterised by four best-practice guiding principles for creating PSC in organisations (Dollard, 2019). Firstly, senior management support and commitment to psychological health and safety,

through involvement and proactivity. This aspect is evident when senior management takes quick and decisive action to address and correct issues that affect psychological health. Secondly, the priority management gives to psychological health and safety, over that of productivity goals. For example, job demands (e.g., work pressure, emotional labour, physical demands) may be modified to make them more manageable, and management have the discretion to offer a variety of resources, such as work flexibility, autonomy, and social support that may buffer demands and reduce work stress. Thirdly, organisational communication is important – how leaders and employers communicate about psychological health and safety, including opportunities for reciprocal feedback about identification of psychosocial risks to mental health, strategies for risk control and hazard management. Finally, organisational participation, which concerns the expectation that for PSC to occur, all levels within the organisation should be involved with stress prevention. For example, including all stakeholders; employees, unions, health and safety representatives in the creation and maintenance of psychological health and safety processes (Dollard, 2019).

With the findings above in mind, climates promoting psychological health and safety are well positioned to decrease MHSD. In high PSC environments, workplace policies, practices and procedures are perceived by employees to value psychological health providing strong communication systems, active involvement in management of stress prevention and fairness and responsivity in resolving threats to psychological health, reducing MHSD (Bond et al., 2010; Dollard & Bakker, 2010; Kwan et al., 2016; Law et al., 2011). When leadership values and commits to psychological health and safety, organisations have stronger PSC. It is likely that this would also create less stigma and discrimination towards mental illness in the workplace. From what is known about stigma, the more normalised an illness is, the less ‘threatening’ it appears,

and consequently less discriminatory behaviours occur (Stull et al., 2013). PSC initiatives and behaviours in organisations are likely to bring psychological health and safety more 'front of mind' for individuals at all levels of organisations, and to have a positive impact on reducing MHSD. This theoretically makes sense and is plausible, however has not previously been explored in the literature. Therefore, this scoping review will explore the impact PSC environments have on protecting employees from the negative impacts of MHSD.

Organisations with high PSC also may experience less MHSD because high PSC may help employees conserve resources. In accordance with Conservation of Resources theory, when resources are used, they must be replenished, creating a cyclical process of protecting, acquiring and recouping resources (Hobfoll, 2001). The more resources an individual holds, the more they can cope with adverse workplace conditions. However, when an individual faces constant resource depletion (through MHSD) they find it harder to obtain new resources triggering a "loss spiral" leading to higher levels of workplace psychological health symptoms (e.g., stress, emotional exhaustion). Employees with low resources may therefore have less capacity to monitor themselves, and may be more prone to engaging in stigmatising or discriminatory behaviours. For the targets of MHSD, they may develop further negative psychological symptoms in low PSC organisations because their resources are depleted, and they have less resources to manage their mental illness. MHSD may increase work-related negative psychological health symptoms because MHSD is likely to erode employee resources. The evidence for these theoretical relationships warrants further investigation so this scoping review will quantify these two theoretical propositions. First, that PSC and psychosocial work conditions will be negatively related to MHSD. Second, that MHSD will be positively related to future negative psychological health outcomes. This evidence will inform future psychosocial

interventions to reducing MHSD, and protect employees experiencing MHSD from further negative psychological health impacts to mitigate perpetuating cycles of harm.

Mental health stigma and discrimination (MHSD)

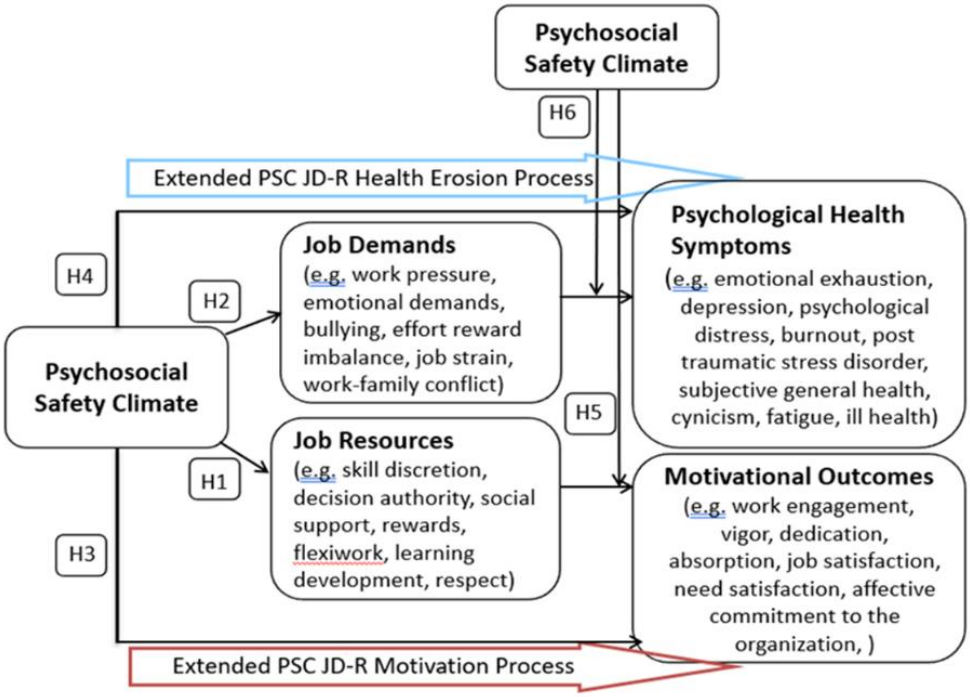
Corrigan et al. (2012) argue that *'all mental disorders strike with a double-edged sword'*, meaning that the symptoms and limitations of mental illness often come hand-in-hand with social stigma and discrimination, adding further to the initial symptoms and impairments. Corrigan and Watson's three factor model (2002, 2003) draws from social perspectives, motivational biases and social-cognitive theories to explain how mental health discrimination occurs. For instance, from a social perspective people might think, *'a person talking to him/herself on the park bench must be crazy'*. According to the motivational bias theory, these cues generate stereotypes about people with mental illness: for example, *'crazy people are dangerous'*; stereotypes then lead to cognitive and behavioural reactions (discrimination), for example, *'I will not allow crazy dangerous people like that to settle in my neighbourhood'.* (Corrigan & Watson, 2002, 2003).

Stigma is prevalent in the workplace and stems from unconscious biases that humans hold about individuals with mental illness (Stull et al., 2013). Mendel et al.'s 2015 study assessed manager perceptions of four case vignettes displaying an employee with different 'diagnoses' (depression, burnout, private crises and thyroid dysfunction), but identical unspecific complaints at work. In nearly all aspects of job performance, the depression 'diagnosis' was perceived more critically by managers than the 'diagnosis' of thyroid dysfunction. Likewise, 'private crisis' was rated less favourably than thyroid dysfunction. Therefore, employees face the challenge of evaluating whether or not to disclose psychiatric disorders, or to conceal them as somatic illnesses (Mendel et al., 2015)Individuals with a mental illness are particularly prone to

stigma and discrimination in a variety of settings. The consequence of this is disguising their own problems or clinical diagnoses to avoid personal prejudice or violence. Discrimination also goes beyond the individual with mental illness, impacting those close to them - family, friends, colleagues and others - simply for being related to people with mental illness may create guilt and shame around the mental illness (Torales et al., 2023). Therefore, it is important to reduce mental health stigma to improve quality of life for individuals with mental illness, and prevent conditions from worsening.

Discrimination, or unfair treatment of individuals based on their mental illness is prevalent. Stuart et al. (2014) found that 37.4% of people being treated for a mental illness experienced discrimination during the last year in one of the following life domains: family relationships, romantic life, school or work life, financial situation and housing situation. People who experience MHSD are far less likely to be employed (Mechanic et al., 2002; Sturn et al., 1999), receive equal pay (Baldwin & Marcus, 2007, Baldwin & Marcus, 2006), and have supportive relationships with coworkers and supervisors (Rüsch et al., 2014; Stuart, 2006). Evidence indicates people are turned down from jobs for their mental health problems, and report avoiding applying for jobs out of fear of discrimination (Thornicroft et al., 2009; Wahl, 1999). Furthermore, employers report concerns that applicants with mental health problems will create problems for work performance outcomes, particularly absenteeism (Brohan et al., 2010).

Figure 1: Psychosocial Safety Climate Model



The above diagram applies to illustrate the theoretical framework, with MHSD in the job demands category.

MHSD is likely to have a negative impact on future psychological health in the workplace. Several studies have shown associations between perceived mental health stigma and greater stress and depression (Malterud et al., 2022; Wright & Rains, 2013; Riggs et al., 2007; Vanable et al., 2006). For example, US immigrant studies found that mental health stigma was positively associated with future stress and depression (Malterud et al., 2022), similarly health-related stigma reduces social support, leading to increased stress and depression (Wright & Rains, 2013).

Fear of discrimination often leads to the decision to conceal one's mental illness characteristics, creating stigma. It is a complex decision whether to disclose one's mental illness, particularly in the workplace, because disclosure carries the risk of negative outcomes like

discrimination (Lasalvia et al., 2012). However, disclosure creates opportunities for employees to receive social support (Corrigan & Rao, 2012), and reasonable adjustments to their working conditions to support performance (Reavely et al., 2012). Those who experience depression and anxiety report significant discrimination associated with their mental illness (Feldman & Crandall, 2007).

Both stigma and discrimination create barriers to social support and achieving life opportunities, which are crucial to the management and recovery from mental illness (Chronister et al., 2013; Rosenfield, 1997). Therefore, the stigma and discrimination of mental illness can be as harmful as the symptoms, leading to family discord, and social rejection (Feldman & Crandall, 2007). In turn, MHSD leads to worsened self-esteem (Link et al., 2001) and life satisfaction (Rosenfield, 1997) for people already struggling with mental illness.

Disclosure

Most employers believe that people with mental health problems should disclose these to their supervisors and, indeed, disclosure allows for the provision of reasonable adjustments that support the person to perform their role (Henderson et al. 2013). However, stigma means that nondisclosure is more likely (Reavley et al., 2016).

Deciding whether to disclose mental health problems in the workplace can be particularly challenging. Brohan et al. (2012) carried out a systematic review of studies assessing beliefs, behaviours and influencing factors associated with disclosure of a mental health problem in the workplace. Their results showed that women were less likely to disclose than men, and people with a diagnosis of mood disorder were less likely to disclose than those with a diagnosis of schizophrenia. Those with less severe symptoms were also less likely to disclose, as were those who were concerned about losing their jobs, felt pressure to fit in or who lacked confidence

about their ability to maintain their professional status (Ellison et al. 2003). Where disclosure is limited, support seeking is difficult for individuals with mental illness in the workplace. Therefore, identification of methods to reduce stigma and protect these workers from developing worsened psychological outcomes is important.

Methods

A scoping review method was chosen because the body of literature surrounding PSC and its impact on MHSD has not yet been comprehensively reviewed, and exhibits a complex and heterogeneous nature not amenable to a more precise systematic review.

A literature search was conducted across two main databases (PsychExtra and ProQuest). A reference list of eligible studies was also checked for additional papers. Only full-text peer-reviewed articles written in English were eligible for this review. The methods for this scoping review were informed by the 22-step checklist PRISMA extension for Scoping Reviews (PRISMA-ScR) (Tricco et al., 2018). Articles using interventions and manager intentions to promote a psychosocially safe workplace climate were reviewed to identify the impact of such interventions across a range of industries and groups.

Two research questions guided this review.

Research Question 1: Are workplace climates promoting high levels of psychosocial health and safety associated with less future MHSD? What psychosocial health and safety interventions are associated with less MHSD in organisations?

The search terms were as follows:

PROQUEST (mental health stigma and discrimination) AND (psychosocial safety climate) AND workplace (1990-2023) (437 results)

PSYCHEXTRA (mental health stigma and discrimination) OR (psychosocial climate) (all years): (16 results)

Research Question 2: Is workplace MHSD positively related to reported work-related psychological health symptoms (e.g., burnout)?

The search terms were as follows: PROQUEST ((mental health stigma AND discrimination) AND workplace AND burnout) AND (la.exact("ENG") AND subt.exact("mental health" OR "mental disorders" OR "stigma" OR "stress" OR "burnout" OR "anxiety" OR "mental depression" OR "workers" OR "employment" OR "employees" OR "mental health care" OR "occupational stress") AND pd(20130814-20230814) AND PEER(yes)) (470 results)
923 studies were reviewed from databases Proquest Central, PsychExtra, and abstracts were read to eliminate non-eligible studies, such as; non-workplace studies, studies analysing pre-and-post Covid19 pandemic impacts without mental health intervention, and studies assessing stigma and discrimination not pertaining to mental health.

A search in the databases produced 923 records, and through a rigorous screening process, 35 papers were included in this review. Due to the limited research in this area, PSC was expanded to all psychosocial workplace climates. The reason many studies were excluded was because they were about either a) stigma not related to mental health (e.g. Ethnicity, gender, age) or b) mental health stigma and/or discrimination occurring outside of the workplace. Some community studies were included to provide context in the scoping review, however the main research question is to investigate the impact of PSC or PSC-promoting actions on MHSD in the *workplace.* The literature available in this area was extremely limited, hence only 35 articles were included for review.

RQ1: Limited articles assessed culture and climate, therefore organisations who implemented psychosocial intervention initiatives were assessed to determine their effectiveness.

RQ2: Articles were screened to identify studies assessing workplace MHSD and work-related psychological health symptoms (e.g. burnout).

Table 1 Eligibility criteria for screening search results and full-text records

Inclusion criteria:

1. The paper is written or published in the English language
2. Only peer-reviewed articles
3. The study should explore a form of psychosocial climate, positive psychosocial interventions or mental health stigma and discrimination in the working population
4. The study was conducted in any part of the world
5. The study was published in 1990 or later

Exclusion criteria:

1. The paper was written or published in any other language than English
2. The paper is not a conference paper, a letter to the editor, pre-print, grey literature, and commentaries
3. The paper did not explore a form of psychosocial climate, positive psychosocial interventions or mental health stigma and discrimination in the working population
4. The paper was published before the year 1990 (PSC was introduced in 2010)
5. Abstracts without full-text records
6. The study was published online

Results

Search results

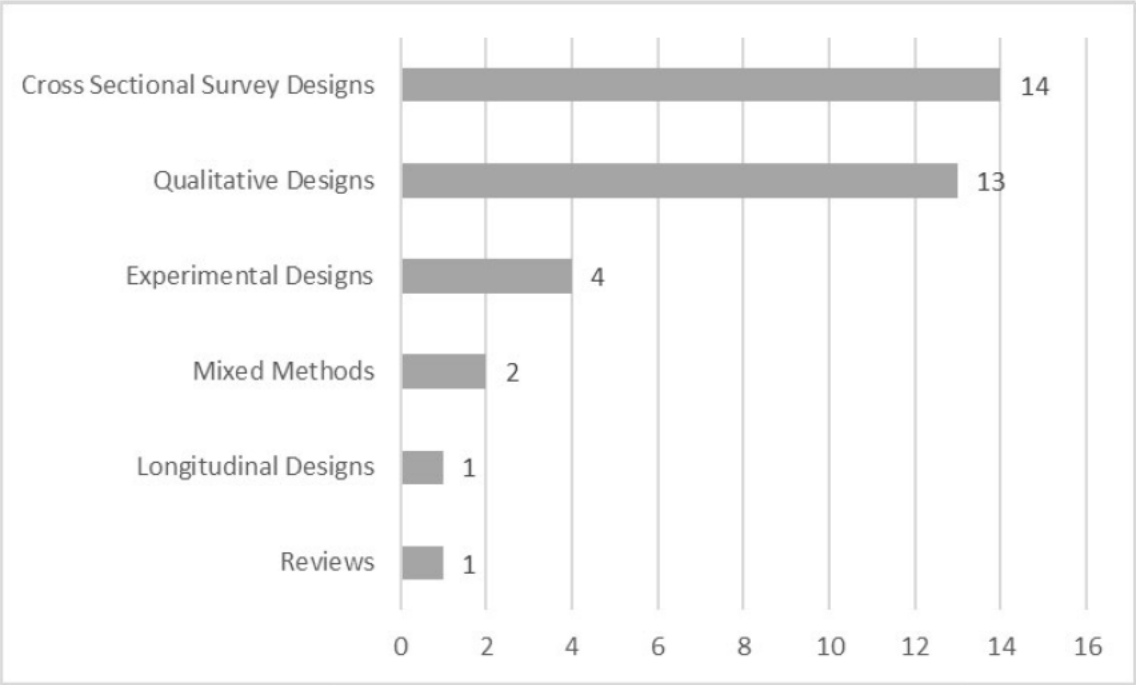
The results from the two main databases yielded 923 records. Criteria were added to the search method to eliminate articles that met exclusion criteria (see Table 1.) and therefore all 923 articles were available for screening. After removing non-full text and records irrelevant to the review, 35 full-text records were available to be included in the thematic synthesis.

Study characteristics

Most reviewed studies used a cross sectional (14) or qualitative (13) design (see Figure 3) and were conducted internationally (United Kingdom, United States of America, Canada, South

Korea, Germany, Australia). Healthcare workers, frontline workers and workers in academia remained the most explored groups, with the remaining studies exploring the general working population.

Figure 3: Study Characteristics Breakdown



Findings

Findings from this review were reported based on the two research questions: **RQ1: Are workplace climates promoting high levels of psychosocial health and safety associated with less future MHSD? What psychosocial health and safety interventions are associated with less MHSD in organisations?**

(RQ2): Is workplace MHSD positively related to reported work-related psychological health symptoms (e.g., burnout)?

PSC and psychosocial workplace climates were found to indirectly impact MHSD. With twelve studies finding that psychosocial workplace climates and cultures had higher rates of mental illness disclosure (Coduti et al., 2015; Faller et al., 2023) and peers being better able to

identify mental illness, while reducing stigma in the workplace (Tynan et al., 2018). Several psychosocial interventions were found to be effective in creating conditions that foster less MHSD, including leadership training in mental health promotion (LMHP), which had a positive impact on managers' knowledge of mental health and mental illness, and on attitudes towards people with mental health problems, and on their self-efficacy to deal with mental health problems at work (Hanisch et al., 2017). Other successful interventions included the Mates in Mining Peer Program, which led to participants and supervisors feeling more confident to identify and support someone experiencing mental ill-health (Tynan et al., 2018). Clarissa et al. (2021) found that cognitive behavioural therapy (CBT) and mindfulness resources were well received by staff in promoting mental health, however, lack of management commitment was a barrier to success. This supports the evidence that for psychosocial climates to be fostered, the commitment of leadership and employers is critical.

Moreover, the psychological theory indicates that PSC acts as a buffer for individuals experiencing MHSD from developing further negative workplace psychological symptoms. As expected, MHSD was found to increase workplace psychological symptoms like burnout (Favre et al., 2023). Discrimination, but not bullying, was associated with higher depression, anxiety and suicidal ideation and lower well-being and resilience (Stratton et al., 2021). Results from Mitake and colleagues (2019) survey of mental health professionals suggest that higher perceived mental-illness-related stigma is associated with more severe burnout. MHSD also was associated with absenteeism and presenteeism (Berry et al. 2021), emotional exhaustion (Favre et al., 2023), less access to social support from non-disclosure (Bikos, 2021; Eguchi et al., 2017) 3 sub-themes were developed from the findings of the reviewed studies. The themes are listed below.

Theme 1: Psychosocially safe workplace cultures and climates were helpful for people with mental illness and other stressors.

Workplace cultures that de-stigmatise mental illness were positive for recovery and reducing further negative psychological symptoms. Factors that may increase likelihood of help-seeking included; systemic factors, access to information and education, quality and influence of relationships, individual characteristics, and organisational processes that will increase the likelihood of accessing mental health services (Burns & Buchanan, 2020). Similarly, Auth and colleagues (2022) found that a workplace culture which de-stigmatises mental illness by encouraging help seeking and open dialogue around mental health may reduce stigma and improve recovery from mental illness in frontline workers. In addition, police cultures (Edwards & Kotera, 2021; Stuart, 2017), and Western cultures of competitiveness and individualism (Smith et al., 2022) may be a more significant contributor to mental illness than the job itself. Coduti et al. (2015) found that companies with supportive work culture (i.e., work-life balance, good benefits and successful wellness programs) had higher mental illness disclosure rates from workers in these environments, leading to more support accessed. On the other hand, O'Donnell et al.'s (2017) study found men were disappointed with the lack of support available, and therefore found it hard to disclose.

Sources of burnout for male health and nursing professionals identified included mental health conditions, as well as cultural considerations (e. g., pressure from coworkers; unsupportive government policies) (Dos Santos, 2023). Similarly, stigmatised cultures also contributed to mental illness in police populations (Edwards & Kotera, 2021). Positively, perceptions of psychological safety culture were found to be associated with engaged work

behaviours in a chronically ill group of employees (Kirk-Brown, 2011). This may indicate that psychosocially safe cultures and climates have potential to protect individuals from MHSD.

Theme 2: Interventions were proposed and effective at reducing MHSD.

In terms of interventions, in light of the prevalence of MHSD, realistic uptake and interest must be considered. Wu et al. (2022) assessed the most realistically considered interventions amongst physicians and found the following. Therapy (63%, selected as 'would realistically consider intervention') and coaching (58%) were the most preferred wellness supports in comparison to group-based peer support (20%) and individual peer support (22%). There was also found to be more stigmatised culture in emergency and internal physicians than other types of doctors. Wu et al. (2021) found top-ranking factors for seeking wellness supports included seeking informal peer support (best: 71%; worst: 0.6%) and support from friends and family (best: 70%; worst: 1.6%). Top-ranking barriers to seeking counseling included time (best: 75%; worst: 5%) and money (best: 35%; worst: 21%). In terms of addiction recovery, vulnerable leadership was found to be a useful tool (Walsh & Smith, 2021), and employees were more likely to disclose mental illness in the presence of supervisor/managerial support (Tynan et al., 2018). Finally, several interventions aimed at increasing organisation-wide awareness of mental health and suicide prevention were effective in reducing MHSD in workplaces (Faller et al., 2023; Tynan et al., 2018; Hanisch et al., 2017) These include the Mates in Mining program targeting peer-based mental health and suicide awareness (Tynan et al., 2018) and the LMHP program targeting leadership mental illness awareness (Hanisch et al., 2017). However, management commitment is shown to be critical to success for these interventions to be successful (Clarissa et al., 2021).

Theme 3: Additional Relevant Findings

Additional findings contributing to existing literature were found, supporting the research that indicates that MHSD leads to negative psychological health symptoms, and work problems. Mental illness-related discrimination was associated with negative psychological symptoms including, depression, anxiety, suicidal ideation and lower well-being and resilience (Stratton et al., 2021) and worse mental health (Napoli et al., 2021). Mental illness-related stigma was shown to be prevalent and pervasive. In Mendel et al.'s (2015) blind-experimental design, managers saw depression as more detrimental to job performance than thyroid dysfunction. Mental illness-related stigma was a barrier to help-seeking (Lee et al., 2020; Eguchi et al., 2017), disclosure (Walsh & Smith, 2021), absenteeism and presenteeism (Berry et al., 2021) and was associated with negative psychological symptoms (Mitake et al., 2019), and self-stigma (Forbes et al., 2019; Stuart, 2017). Reporting mental illness was perceived as a personal and professional risk in the context of frontline workers (Bikos, 2021) and academic staff (Smith et al. 2022). In medical contexts, stigma led to burnout and emotional exhaustion (Favre et al., 2023). Mental illness-related stigma also prevented peer support officers from supporting colleagues, as they felt afraid of the risk to their career (Balková Miluše, 2022), and inept to deal with mental illness issues (Graves et al., 2022).

Table 2: Literature review

Author	**Context**	**Sample**	**Main Findings re. climate**
Research Question 1			
Hanisch, S. E., Birner, U. W., Oberhauser, C., Nowak, D., & Sabariego, C. (2017).	Leadership Training in Mental Health Promotion (LMHP), a digital game-based training program for leaders. A 1-group pre-post design and a 3-month follow-up were used for training evaluation.	48 managers of a global enterprise in the United Kingdom	Positive impact of the Web-based training program on managers' knowledge of mental health and mental illness (P<.001), on attitudes toward people with mental health problems (P<.01), and on their self-efficacy to deal with mental health situations at work (P<.001).

Tynan, R. J., James, C., Considine, R., Skehan, J., Gullestrup, J., Lewin, T. J., . . . Kelly, B. J. (2018).	Mates in Mining Peer Program (a peer-based mental health and suicide prevention program) and supervisor training.	1275 miners and 117 supervisors	Participants and supervisors were more confident that they could identify and support an employee experiencing mental ill-health.
Coduti, W. A., Tugman, K., Bruyère, S.,M., & Malzer, V. (2015).	Supportive work culture (i.e., work-life balance, good benefits, successful wellness programs).	Six companies participated in the study, and all had over 2000 employees.	Workers in these environments had higher disclosure rates.
Faller, Y. N., Peynenburg, V., Tessier, E., Thiessen, D., & Hadjistavropoulos, H. D. (2023).	Online psychoeducation course or wait-list control (WLC). The course provided education on symptoms, accommodations, tips for requesting accommodations and making disclosures, and coping strategies.	89 participants with symptoms of depression and/or anxiety.	Partial disclosures were associated with supportive organizations and supervisors. No group differences were found on accommodation use, symptoms, workplace relationships, or comfort with disclosure.
Clarissa, C., Quinn, S., & Stenhouse, R. (2021).	CBT and relaxational resources.	Framework analytic approach across NHS board.	Although cognitive behavioural and relaxational interventions were well received by staff, lack of management commitment was a barrier to success.
Rikkers, W., & Lawrence, D. (2022).	Barriers to help-seeking questionnaire.	In total, 14,868 employees participated in the survey (Police = 8,088, Ambulance = 3,473, Fire and Rescue = 2,975, State Emergency Service = 332).	The most commonly reported barrier was preferring to handle problems on one's own or with family/friends.
Fitore, H., Arzana, M., & Blanck, P. (2022).	USA survey of lawyers' willingness to disclose disability.	3590 USA lawyers	Less disclosure of invisible disabilities like mental illness. Smaller firms were less likely to disclose.
Dos Santos, L. M. (2023).	Qual. Interviews re. Sources of burnout in male nurses during covid19.	40 male health and nursing professionals	Reasons for burnout: my physical and mental health conditions, surrounding environments and individuals: pressure from my co-workers, and political considerations: unsupportive government policies.
O'Donnell, Sue, RN, MN, PHD, MacIntosh, Judy, RN, BN,M.Sc(N.), P.H.D., & Bulman, Donna, BN, MN,M.A.D.E.D., P.H.D. (2017).	Secondary analysis of data from two existing qualitative studies focused on men's experiences of being bullied.	56 men from Atlantic Canada using newspaper, radio, and computer advertising	Men were disappointed by the nature and availability of workplace support to address the problem. As a result, men faced ongoing bullying and health consequences. Men consistently identified that without workplace support to put a stop to the bullying, it was difficult to maintain health and persist at work.

Kirk-Brown, A., & Dijk, P. V. (2011).	Online surveys	92 employees with chronic illness 512 healthy employees	Perceptions of psychological safety fostered engaged work behaviours in the vulnerable group with chronic illness
Research Question 2			
Stratton, E., Player, M. J., Dahlheimer, A., Choi, I., & Glozier, N. (2021).	An online cohort survey was conducted amongst employees of an Australian mining company.	A total of 580 employees (82% male) participated.	Discrimination, but not bullying, was associated with higher depression, anxiety and suicidal ideation and lower well-being and resilience.
Eguchi, H., Wada, K., Higuchi, Y., & Smith, D. R. (2017).	Only survey of participants' perception of opportunities in their workplace for individuals with a psychiatric disorder returning to work (colleagues' negative perception) and psychosocial factors	3,710 employed individuals aged 20 to 69 years in Japan.	Colleagues' negative perception was associated with low workplace social support (which is not helpful for people with psychiatric illness returning to work).
Napoli, A. D., Rossi, A., Baralla, F., Ventura, M., Gatta, R., Perez, M., . . . Petrelli, A. (2021).	Surveys	12408 immigrant workers in italy	Self-perceived workplace discrimination was associated with worse MH -1.7
Mitake, T., Iwasaki, S., Deguchi, Y., Nitta, T., Nogi, Y., Kadowaki, A., . . . Inoue, K. (2019).	In this cross-sectional study, nonprofessional occupational mental health staff's perceived mental-illness-related stigma was assessed using Link's Devaluation-Discrimination Scale, and their burnout was assessed using the Maslach Burnout Inventory.	Mental health staff, 228 eligible respondents were surveyed.	The results suggest that higher perceived mental-illness-related stigma is associated with more severe burnout.
Berry, C., Niven, J. E., Chapman, L. A., Valeix, S., Roberts, P. E., & Hazell, C. M. (2021).	This was a mixed methods psychological study using cross-sectional data provided by researchers.	3,352 UK-based PGRs. (post grad researcher)	Both quantitative and qualitative results show that experiences of mental health-related stigma are associated with greater absenteeism and presenteeism.

Bikos, L. J. (2021).	Interviews	116 Canadian police officers	Results indicate that most officers believe stigma toward mental illness in their workplace remains, despite senior management messaging and program implementation. Reporting mental illness was often seen as high risk, both personally and professionally. Policewomen, constables and those on leave reported statistically significant higher levels of perceived stigma and risk
Edwards, A., & Kotera, Y. (2021).	Police interviews	5	Findings indicate police culture and attitudes to mental health may contribute to the causes of psychological illness, rather than the nature of the job itself. Increased education and awareness surrounding mental health have been shown to be fundamental in how an officer reacts to stress, but change is needed at a managerial level.
Favre, S., Bajwa, N. M., Dao, M. D., M.-C. Audétat Voirol, Nendaz, M., Junod Perron, N., . . . Richard-Lepouriel, H. (2023). A	Cross sectional survey	Three hundred and eight physicians participated in the survey (response rate: 34%).	Physicians with burnout (47%) were more likely to hold stigmatized views. Emotional exhaustion was moderately correlated with perceived structural stigma ($r = 0.37$, $P < .001$) and weakly correlated with perceived stigma ($r = 0.25$, $P = 0.011$).
Burns, C., & Buchanan, M. (2020).	Qualitative interviews about barriers to seeking help.	20 serving Royal Canadian Mounted Police officers in the lower mainland of British Columbia, Canada	The findings encompass five main themes: the importance of systemic factors, access to information and education, quality and influence of relationships, individual characteristics, and organizational processes that will increase the likelihood of accessing mental health services.

Auth, N. M., Booker, M. J., Wild, J., & Riley, R. (2022).	A qualitative evidence synthesis was conducted with 24 qualitative studies		Following traumatic exposure, frontline workers identify benefiting from recovery time and informal support from trusted colleagues. A culture which encourages help seeking and open dialogue around mental health may reduce stigma and improve recovery from mental ill health associated with trauma exposure.
Elliott, M., & Reuter, J. C. (2022).	in-depth interviews	56 people diagnosed with mental illness who are in the workforce	Working was found to be helpful for people with mental illness due to social connection, accountabiity, and more empathy for others. But symptoms can cause angry outbursts.
Smith, J., McLuckie, A., Szeto, A. C. H., Choate, P., Birks, L. K., Burns, V. F., & Bright, K. S. (2022).	In-depth, semi-structured interviews were conducted	Nine university faculty members who self-identified as having mental illness–related concerns.	Findings suggest that competitiveness and individualism may perpetuate stereotypes that mental illnesses are inherent weaknesses, and that seeking help is a barrier to academic success due to stigma.
Forbes, M. P., Iyengar, S., & Kay, M. (2019).	interviews	15 junior doctors	Junior doctors reported ingrained stigma, discrimination, and self-stigma with help-seeking behaviours, especially for mental health issues.
Stuart, H., PhD. (2017).	Survey data were collected from officers attending a mandatory workshop (90.5% response).	133 front-line police officers	Findings highlight that (a) Police-to-police mental illness stigma may be a particularly strong feature of police cultures; (b) police should be a focus for targeted anti-stigma interventions.
Niha, M. H., Spiers, J., Kobab, F., & Riley, R. (2023).	Participants were asked about their experiences of discrimination, although some also discussed it in response to open-ended questions about sources of PD.	39 junior doctors in the NHS England	Racial and gender Discrimination is associated with elevated levels of Psychological Distress, whilst negatively impacting workforce sustainability and retention.

Lee, E., Jeong, Y. M., & Su, J. Y. (2020).	A cross-sectional study with 184 nurses at one general hospital in South Korea was conducted employing a self-administered survey	184 nurses at one general hospital in South Korea	The higher is the level of depression, the higher is the level of self-stigma, and the lower is the positive attitude toward psychiatric help (Lee et al., 2020)
Burns, C., & Buchanan, M. (2020).	Qualitative interviews	20 serving Royal Canadian Mounted Police officers in the lower mainland of British Columbia, Canada.	Five main barriers to help-seeking: the importance of systemic factors, access to information and education, quality and influence of relationships, individual characteristics, and organizational processes.
Graves, J., Flynn, E., Woodward-Kron, R., & Hu, W. C. Y. (2022).	Qualitative interviews	10 medical students	Barriers to offering peer support due to confidentiality, stigma and lack of expertise.
Wu, A., Parris, R. S., Scarella, T. M., Tibbles, C. D., Torous, J., & Hill, K. P. (2022).	This cross-sectional study used best–worst scaling (BWS) physicians prioritised 16 work-stressors and 4 wellness interventions	267 residents across 9 disciplines	Therapy (63%, selected as 'would realistically consider intervention') and coaching (58%) were the most preferred wellness supports in comparison to group-based peer support (20%) and individual peer support (22%). More stigmatised culture in emergency and internal physicians.
Walsh, C. A., & Smith, J. (2021).	An exploratory qualitative design was used.	Sixteen in-depth interviews were conducted privately with 10 deans and 6 CMHPs (staff wellness, support staff, counsellors, and human resources roles).	(1) Disclosure was rare, and most often involved alcohol; (2) Addiction stigma and non-disclosure were reported to be affected by university alcohol and productivity cultures (3) Reducing addiction stigma may involve peer support, vulnerable leadership (e.g., openly sharing addiction-recovery stories), and non-discriminatory protective policies.

Wu, A., Radhakrishnan, V., Targan, E., Scarella, T. M., Torous, J., & Hill, K. P. (2021).	This study aims to use an econometric best-worst scaling (BWS) framework to survey internal medicine resident physicians to establish help-seeking preferences	77 Internal medicine resident physicians	Top-ranking factors for seeking wellness supports included seeking informal peer support (best: 71%; worst: 0.6%) and support from friends and family (best: 70%; worst: 1.6%). Top-ranking barriers to seeking counseling included time (best: 75%; worst: 5%) and money (best: 35%; worst: 21%).
Tromans, S. J., Drewett, A., Lee, P. H., & O'Reilly, M. (2023).	An online survey was developed, containing both quantitative and qualitative elements. Survey invitations were disseminated through the National Police Autism Association	117 Autistic/ADHD police officers	Police force employees who are autistic and/or have ADHD reported that their conditions provided both benefits and challenges with respect to policing work, and that they had requested related workplace adjustments, although such adjustments frequently do not take place.
Balková Miluše. (2022).	semi structured interviews	9 peer workers	No stigma was encountered but peer workers felt afraid of calling themselves peer workers because they could struggle to find a new job after due to their label.
Hashmi, S. D., Shahzad, K., & Abbas, F. (2022).	Multi wave survey data	Multi-wave data were collected from 304 female employees working in project-based organisations in the information technology industry in Pakistan.	The results also show that gender harassment leads to burnout causing emotional exhaustion, depersonalisation and reduced personal accomplishment among the victims. However, psychological capital helps victims cope with these adverse effects of gender harassment.
Mendel, R., Kissling, W., Reichhart, T., Bühner, M., & Hamann, J. (2015).	Randomized experimental study incorporating four case vignettes displaying an employee with different 'diagnoses' (depression, burnout, private crisis and thyroid dysfunction), but identical unspecific complaints.	748 managers from german companies	Managers saw depression as more critical to job performance than thyroid dysfunction. Burnout was not stimatising. Employees have to evaluate if they disclose psychiatric disorders or conceal.

Discussion/Implications

Mental health research has focused on how symptoms and disabilities interfere with personal wellbeing, however the literature lacks understanding of stigma and the development of approaches to erase it. It may be beneficial to reduce mental health stigma and increase disclosure, because the benefits of disclosure are likely to outweigh the risk of discrimination, however this is an area that remains unclear in the literature and must be investigated further (Reavley et al., 2016).

In alignment with Conservation of Resource (COR) Theory (Hobfoll, 1989), Hashmi et al., (2022) found that psychological capital (e.g., resilience, optimism) were better protected against the burnout resulting from sexual harassment in the workplace. Here is evidence that personal resources are a factor when considering how generally harassment or discrimination may be overcome, and that a 'buffer' moderation effect is possible to protect individuals from burnout. However, based on other studies found in this review, (Hashmi et al., 2022) personal psychological capital is 'nice to have' but not necessarily the only option or intervention available to organisations wishing to improve outcomes, climate and culture.

Self-stigma was a relevant finding which contributes to negative psychological outcomes and lack of help-seeking. The higher the level of depression, the higher is the level of self-stigma, and the lower is the positive attitude toward psychiatric help (Lee et al., 2020). This theme in the review supports the notion that in the workplace, many individuals stigmatise their own mental health problems, which not only contributes to a non-psychosocially safe climate or culture, but worsens their ability to self-disclose, and seek help. This phenomenon was particularly prevalent in the literature surrounding frontline workers like police and ambulance, and healthcare workers (Rikkers & Lawrence, 2022). These helping professions deal frequently

with patients and people with mental illness, and work in situations where they are required to support and help those who require help. This may lead to these workers creating a distinction between themselves and their patients, and therefore deny sharing characteristics with them like mental illness, as this may appear to undermine their professional role. Nurses, in particular, suffer from personal and professional problems due to depression, as they do not easily receive expert help on their psychiatric problems, usually only considering it last (Jang, 2014; Lee & Son, 2007). In police populations, the self-stigma is characterised by fear of being perceived as weak or incompetent, concerns about being labelled unfit for duty, and worry that accessing psychological support will impact future career advancement. These things can affect the decision to seek help (Burns et al., 2020). This could explain the self-stigma about mental illness so prevalent in the literature regarding frontline and healthcare workers, and reiterates the need for workplace cultural interventions that normalise and de-stigmatise the experience of mental illness for workers.

Another notable factor influencing the decision to seek help in police populations is culture. Participants across several frontline worker studies (MacDermid et al., 2021; Burns et al., 2020) referenced the "suck it up" attitude that was required of them to display when experiencing difficult circumstances on the job. For example., *"The environment I was in at work was very much of a suck it up attitude",—'suck it up buttercup attitude'—we are supposed to have thick skin"* (Burns, et al., 2020). In addition, several participants referred to seeing a psychologist as a *'career stopper'* because "*that showed a sign of weakness that this job is too much for you."* This culture as referenced by frontline workers is a clear barrier to help seeking for those experiencing mental illness at work, and supports the theory that PSC interventions could be of benefit. PSC shows all workers that managerial commitment is in place to prioritise

worker psychological health. Rikkers and Lawrence's (2022) study surveying frontline workers found that 'preference to deal with one's own problems' was the greatest barrier to help seeking. Increased training in mental health literacy for managers, while alleviating career concerns and perceptions of stigma among all personnel, was recommended.

As expected, organisations with a lack of management commitment to these initiatives were less successful. For example, (Clarissa et al., 2021) suggest that managers are in the best position to assess job demands and resources, and therefore have a pivotal role in the success of any intervention to address mental health stigma and discrimination. For example, findings from Canadian qualitative police interviews indicate that organisational processes that increase the likelihood of accessing mental health services have a large impact on officers' decisions to seek help for mental illness. Managers are the ones who can set up these organisational processes and therefore influence the organisational climate. Therefore, taking steps as set up by Zadow and Dollard (2016) to improve psychosocial safety climate in organisations is a purposeful intervention to protect workers from further development of negative psychological outcomes resulting from stigma or discrimination.

The literature identified areas where mental illness can be related to poor performance, for example in the addiction space. Addiction is one of the most stigmatised public health issues and is very prone to non-disclosure (Walsh et al., 2021). Therefore, to mitigate further harm in the addiction space for employees it is recommended that non-discriminatory protective policies are advertised, along with vulnerable leadership (e.g., openly sharing addiction recovery stories from a leadership perspective) (Walsh et al., 2021). Vulnerability in leadership is a useful antidote to MHSD. In addition, Holttum (2017) compared two cases where mental health workers either concealed or disclosed their own service use, finding that the disclosure led to a

contagion effect of more mental health professionals choosing to disclose and therefore increase recovery and social inclusion for more service users. Here are themes where vulnerability and disclosure can have positive implications for workers. 45% of Australians aged between 16 and 85 experience a mental illness at some point in their life, while one in five Australian adults will experience a mental illness in any given year (ABS, 2007). These statistics demonstrate how prevalent mental illness is and how the stigma associated with mental illness is inconsistent in comparison. Therefore, vulnerability and leadership commitment are an integral part to ensuring the message of normalising mental illness is communicated.

The Hu (2022) study found that peer-support programs in a medical student context were ineffective for help-seeking where social relationships were not established prior. The main reasons for this were found to be concerns about initiating and offering support due to confidentiality, stigma and lack of expertise. Again, without the confidence that managers and structures are in place to support those with mental illness, participants are hesitant to disclose for fear of repercussions. It is worth noting that medical professionals would consider the following interventions: psychological therapeutic interventions (63%), coaching (58%), group-based peer support (20%) and individual peer support (22%) for work-related stress (Wu et al., 2022). These preferences differed by study with Wu et al., (2021) finding informal peer support as a higher preference (71%) than counseling. The literature is unclear about individuals' preferences for help-seeking, as it likely depends on the individual and their context. However, what is evident across the literature is that self and organisational cultural stigma, and time, appear to be barriers to engaging with any forms of help. This further highlights the need for systemic and managerial commitment to mental illness support and reducing stigma, or individual workers/students will not feel safe to disclose or seek help.

In neurodivergence research, Tromans et al., (2023) investigated experiences of police force employees with autism and ADHD. Of the autistic participants who viewed themselves as requiring workplace adjustments owing to their autism diagnosis, only 55% (*n* = 22) reported that such adjustments had been made. However, the majority (n = 43; 81%) of participants stated that their autism provided benefits to them with respect to policing work. It is important to note that where reasonable adjustments are required, they are not always being provided, which may further perpetuate stigma and nondisclosure. Therefore, when delivering PSC interventions, managerial commitment and accountability are crucial.

The research on organisational strategies for reducing the impact of stigma indicates that multi-level strategies are likely to be most effective. When changing culture and climate, it is important to note that these things must be addressed at all levels within an organisation, in particular the top levels (Cometto et al., 2022; Newaz et al., 2022). Any interventions should ideally be considered at the organisational, workgroup and individual levels to cover the broad aspects of MHSD. Although individual studies are interesting and useful within smaller group interventions, to create cultural change at a whole-organisation level it is critical to address issues with stigma from a multi-level perspective. Hence, this review supports the PSC theory for creating lasting change through climate shifts.

Limitations

Very few studies in this scoping review that met criteria were longitudinal. As such, it is difficult to say with certainty that PSC is causing MHSD or reducing the impacts of MHSD. Very minimal longitudinal research has been conducted in this area, and therefore this highlights an area for future research. Additionally, many of the articles included in this review were qualitative in their design. Due to the varied experiences regarding stigma, this was an optimal

method for analysing data in a rich and meaningful way. However, the usual limitations of qualitative research are noted; difficulty assessing rigor and researcher subjectivity when analysing results. In addition, in this review it is more difficult to collate themes from qualitative data - however this is preferable given the complex nature of the topic. This review has been about scoping the complexities around stigma and how this can be addressed by PSC-based interventions, given that stigma is not a clear-cut concept, nor is it experienced in the same way by all individuals. In addition, MHSD and PSC have not been commonly researched, hence the scoping review and limited number of articles.

Another weakness of this review is that anti-stigmatising interventions have some downsides. As explored by Mcgonagle et al., (2014), compensatory behaviours can be a double-edged sword - strategies to reduce harm should only be proactive, not reactive as to not cast light on the targets of discriminatory behaviour (Mcgonagle et al. 2014). This concept is understudied and warrants further research to ensure interventions are not doing harm, but reducing stigma as they are intended.

Additionally, the majority of studies found during searches were about stigma and discrimination towards patient mental health, ethnicity, sexual orientation, or analysing worker's mental health pre- and post Covid19 pandemic. There were not many articles assessing *worker* MHSD and the impacts. This is likely due to the stigma itself, and the lack of disclosure of mental illness in the workplace, and the difficulty obtaining a sample of workers who experiences mental illness and discrimination and will disclose such. Therefore, more articles are required to conduct a more thorough review and further research is required. However, the results of this study are in line with psychological theory and literature, and therefore it is recommended that multi-level organisational PSC interventions are implemented accordingly.

Mental health stigma and discrimination have significant negative consequences for people with mental health problems in terms of social exclusion, community activities and namely workplace opportunities. Moreover, there are significant measurable economic impacts in terms of employment, income, health service use and social participation (Evans-Lacko et al., 2015; Wright et al., 2015). Although evidence is growing in relation to effective interventions to reduce stigma and discrimination (Corrigan et al., 2012; Thornicroft et al., 2016), organisations should use targeted, multi-level interventions to ensure they are adopting a proactive, not reactive 'band-aid fix' approach. Although this review has its limitations, the theory and qualitative exploration reviewed here outlines that cultural interventions are likely to be effective in creating PSC, which will protect employees with mental illness from developing further negative psychological symptoms in the presence of MHSD.

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