Abstract

The aim of this systematic review was to determine the quality and comprehensiveness of guidelines developed for employers to detect, prevent, and manage mental health problems in the workplace. An integrated approach that combined expertise from medicine, psychology, public health, management, and occupational health and safety was identified as a best practice framework to assess guideline comprehensiveness. An iterative search strategy of the grey literature was used plus consultation with experts in psychology, public health, and mental health promotion. Inclusion criteria were documents published in English and developed specifically for employers to detect, prevent, and manage mental health problems in the workplace. A total of 20 guidelines met these criteria and were reviewed. Development documents were included to inform quality assessment. This was performed using the AGREE II rating system. Our results indicated that low scores were often due to a lack of focus on prevention and rather a focus on the detection and treatment of mental health problems in the workplace. When prevention recommendations were included they were often individually focused and did not include practical tools or advice to implement. An inconsistency in language, lack of consultation with relevant population groups in the development process and a failure to outline and differentiate between the legal/minimum requirements of a region were also observed. The findings from this systematic review will inform translation of scientific evidence into practical recommendations to prevent mental health problems within the workplace. It will also direct employers, clinicians, and policy-makers towards examples of best-practice guidelines.

Key words: best-practice, workplace, mental health, guidelines, systematic-review, content-analysis

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Introduction

Mental health problems are prevalent in all working populations around the world (Organisation for Economic Cooperation and Development, 2013). In a recent review by the Organisation for Economic Cooperation and Development (OECD), it was estimated that 5% of working populations in high income countries are affected by severe mental health problems, with a further 15% affected by moderate mental health problems (OECD, 2013). Of those affected, it has been reported that workers with common mental health problems, including depression, generalised anxiety, and simple phobia, as well as subclinical problems, such as generalised distress, show the highest participation rates at work (Hilton et al., 2008; Sanderson & Andrews, 2006). Mental health problems amongst working populations are also very costly to society, families, individuals, health systems, and employers, with figures indicating that work-related mental health problems account for 3-4% of gross domestic product in Europe alone, with these social costs anticipated to only increase (International Labour Organisation, 2000; OECD, 2013).

Often it is assumed that mental health problems only develop outside of the workplace and are not the responsibility of the employer. There is growing evidence that poor psychosocial working conditions, commonly referred to as 'job stressors,' can increase risk for developing both clinical and sub-clinical disorders, including, depression, anxiety, burnout, and distress (Harvey et al., 2017; Joyce et al., 2016; LaMontagne, Keegel, Louie, & Ostry, 2010; LaMontagne, Keegel, Louie, Ostry, & Landsbergis, 2007; LaMontagne et al., 2014). Job stressors influencing mental health outcomes can be individual-level stressors, or stressors at the level of the work-group or organisation (Broom et al., 2006; D'Souza et al., 2003; LaMontagne et al., 2010; Martin et al., 2014). It is now well established in the literature that early identification and modification (i.e. primary prevention) of these risk factors is the most effective way to reduce the burden of mental health problems in working populations. Furthermore, primary prevention has been found to be most effective when implemented alongside secondary and tertiary prevention and when interventions target both individual employee factors, as well as organisational level factors (Giga et al., 2003; LaMontagne et al., 2007). Primary prevention of workplace mental health problems aims to reduce the incidence of mental health problems by modifying or removing potential risk factors at their source. Secondary prevention is worker-directed and aims to provide employees identified as ' at risk' with the appropriate skills to cope in stressful conditions.Tertiary prevention

involves treating employees already affected by a mental health condition, and includes rehabilitation and supporting the employee's return to work (Cahill, 1996; Hurrell & Murphy 1996; Kelloway et al., 2008; LaMontagne et al., 2007; LaMontagne et al., 2012). Recent evidence supports this, and indicates that favourable workplace conditions have a positive effect on the mental health outcomes of employees, both facilitating the recovery from mental illness as well as enhancing mental well-being (Modini et al., 2016; Sledge & Lazar, 2014). Further, secondary mental health care in the workplace has been found to be both feasible and accepted by employees and reduces the burden of mental health conditions on standard outpatient settings (Rothermund et al., 2017). This is promising as it illustrates that workplaces can be an effective context for preventing, detecting and managing mental health problems within the workplace and in society more broadly.

With growing recognition of the burden of work-related mental health problems and a high rate of labour market participation of workers with common mental health problems, there has been an increasing number of interventions developed to prevent, detect, and manage depression and anxiety within the workplace (Alexander & Campbell, 2011; Martin et al., 2009; Sanderson & Andrews, 2006; Wang et al., 2007). While this is a positive development, interventions designed to target common mental health problems have tended to emerge separately, and from different fields of expertise, including medicine, psychology, public health, management, and occupational health and safety (LaMontagne et al., 2014). Consequently, many existing interventions fail to take a holistic and integrated approach to workplace mental health as they often only focus on one area of intervention. For example, the most common response cited by human resources managers and occupational health and safety officers, when asked how they would respond to employee stress, is to provide access to an employee early assistance program (EAP; Page et al., 2013). Although EAPs can be effective, for an intervention to be truly preventative it needs to (i) modify and minimise risk factors related to the nature of work, (ii) promote positive and protective factors within the workplace, and (iii) manage illness, regardless of cause (LaMontagne et al., 2014). Thus, primary, secondary, and tertiary approaches must target both the individual employee, as well as organisational-level factors (LaMontagne et al., 2007; LaMontagne et al., 2014).

To translate research in these areas into useable and practical recommendations for workplaces, a growing number of guidelines have been developed for employers to use.

Although this burgeoning of workplace mental health guidelines is encouraging, it also means that employers and clinicians are now faced with the challenge of deciding which guidelines to recommend or follow, and under what circumstances. The Institute of Medicine (IOM) specifies that best practice guidelines are documents with specific recommendations to minimise variation in practice and are informed by a systematic review of the literature (IOM, 2011). The IOM states that it is this systematic review of the literature that distinguishes guidelines from other types of recommendations, expert advice, or consensus statements. However, due to differences in access to resources and variation in national and state based jurisdictions, the content and development process of guidelines often vary greatly by country and region (Eccles, 2012; IOM, 2011). Accordingly, it is difficult for employers to select and decide which guidelines are most appropriate to use or recommend in which setting, which recommendations apply to whom, and which guidelines are of the highest quality (Staal et al., 2003).

Several studies have reported that guideline-driven occupational care is effective, however, due to low uptake in this area this effect is generally low (Nieuwenhuijsen et al., 2003; Rebergen et al., 2010). This has been found to be true for clinical guidelines more generally, with clinicians also displaying low uptake (Hepner et al., 2007; Kennedy et al., 2010; Mulley, 2009). Exploring the development process of the recommendations has been found to be key to successful implementation (Hulshof & Hoenen, 2007). Several reviews have evaluated the quality of occupational guidelines and highlighted that a lack of consultation with relevant professional and population groups, a narrow review of the literature and a lack of extra resources to assist in the implementation of recommendations are common (Cates et al., 2006; Hulshof & Hoenen, 2007; Kinnunen-Amoroso et al., 2009; Manchikanti et al., 2008; Staal et al., 2003). These shortcomings may explain why employers and relevant health professionals often fail to engage with recommendations. However, it is important to note that extant reviews have not evaluated guidelines specific to mental health in the workplace. Therefore, this paper adds values as we will review both the content and quality of these specific guidelines. This will help researchers to better translate scientific evidence into useable, practical recommendations to prevent mental health problems within the workplace and direct employers, clinicians, and policy-makers towards examples of best-practice.

Previous reviews of mental health guidelines in the workplace have been narrower in scope (Dewa et al., 2016; Joosen et al., 2015; Leka et al., 2015). For example, a recent review

examined best practice guidelines, but only guidelines designed for use by health professionals (Joosen et al., 2015). Another review focused on guidelines developed for use by employers, however, its focus was on return-to-work pathways (Dewa et al., 2016). Other reviews have also examined workplace mental health frameworks, but these have been limited to policy documents, applicable within the European Union (Leka et al., 2015). Two further reviews have examined occupational health and safety guidelines, but were not specific to mental health (Cates et al., 2006; Hulshof & Hoenen, 2007).

Therefore, the aims of this systematic review were to (1) determine the quality of existing workplace mental health guidelines, and (2) to assess the comprehensiveness of included recommendations by addressing the three threads of the integrated approach: preventing harm and minimising risk factors within the workplace, promoting positive and protective factors within the workplace, and managing mental health problems regardless of cause.

Methods

Search Strategy

As this review sought to locate guidelines developed for and freely available to workplaces, the search strategy focused on grey literature. Grey literature is defined as any publication not controlled by commercial publishers, but rather produced by government, academic, business or industry (University of Toronto Gerstein Science Information Centre, 2011). We used items from PRISMA to guide reporting for this study (Mohr et al., 2015).

This review did not involve collection of any primary data and therefore ethics approval was not required. The search strategy was developed in consultation with an expert research librarian. Due to the difficulty in retrieving documents and variation in language and terminology used across regions, Google Advanced was identified as the most appropriate search engine for the initial search, as it uses intuitive rather than BOOLEAN search algorithms (Lopez et al., 2012).

Searches in Google Advanced were restricted to the major English language speaking countries: Australia, Canada, United Kingdom, United States, New Zealand and Ireland. Using Google Advanced functions, searches were conducted separately for each region. The

selection of documents was restricted to the first 50 results in each search (Lopez et al., 2012; Dewa, et al., 2016). This is consistent with the algorithm used by Google to search for the most relevant hits (Lopez et al., 2012). Duplicates were deleted. We also contacted relevant stakeholders from the World Health Organisation, International Labour Organisation, key academic and non-academic sources including published researchers, government agencies in Canada, Australia and the United Kingdom and several non-profit organisations. Further, when documents appeared to have missing information (e.g. no information included regarding how the guideline was developed), the guidelines authors were contacted to seek additional information.

Searches were conducted between May 2016 and July 2016. The following key search terms were used in Google Advanced (Dewa, et al., 2016). It must be noted that only one search term was used for 'workplace' and 'guidelines' as google advanced algorithms are intuitive and use algorithms that search based on similar terms (Lopez et al., 2012). To ensure that we were not missing documents, by only including one search term, we piloted other search strings and had close to 100% overlap in search results and therefore different search strings were deemed unnecessary.

- mental health OR psychological health + workplace + guidelines

Portals of best practice were identified through Google searches and consultation with experts. The National Guidelines Clearing House, US Centres for Disease Control and Prevention, Guidelines International Network, Public Health Agency of Canadian Best Practice Portal and the Canadian Centre for Occupational Health and Safety were searched using the above terminology. Extensive manual searching was also conducted in Google, based on reference lists in the documents identified as part of the initial searches.

Eligibility Criteria

The grey literature search included all workplace mental health guidelines that were developed for use by employers. Documents were excluded if they were not published in English; not developed by an authoritative source (e.g. were developed by a private company and not intended for wide spread dissemination); if recommendations were only published as

fact sheets, PowerPoints, advertisements, or developed for a specific program (e.g. return to work, employee assistance) and/or target audience (e.g. nurses or teachers).

Based on the above eligibility criteria, the following inclusion criteria were used for screening and assessed in two phases:

1. Documents included recommendations from an authoritative source for prevention and/or management of mental health problems in the workplace
2. Documents were specifically developed for use by employers

In phase A of the screening process, all documents were screened and assessed based on their title as per criteria 1 and 2. In phase B, the full text documents were assessed against criteria 1 and 2, and included/excluded accordingly. This screening process was conducted independently by two reviewers (KM and LB) and interrater reliability corrected for chance agreement (0.89) was calculated for agreement of inclusion. Where agreement could not be reached between the two reviewers, the documents were assessed by a third independent reviewer (KS).

Data Extraction and Study Coding

Included guidelines were coded using the integrated approach as the framework (LaMontagne et al., 2007; LaMontagne et al., 2014; LaMontagne et al., 2016). Key elements in this framework include recommendations for (i) primary, (ii) secondary and (iii) tertiary prevention. The reviewed guidelines were also coded in relation to other key questions including: (1) Are there recommendations that target the individual employee e.g. enhancing personal resilience? (2) Are there recommendations that target organisational level factors e.g., changing organisational culture? (3) Does the document outline the legal requirements of the region that the document was intended for dissemination e.g., minimise psychosocial risk factors? (4) Does the guideline include recommendations that outline how to promote and enhance protective factors within the workplace? (LaMontagne et al., 2014).

Each document was given a score of 0 (no mention of the above criteria), 1 (mention, but provides no action), and 2 (mention and provide a line of action) on each factor outlined above (i.e., primary level, secondary level, tertiary level, recommendations targeting

organisational factors, recommendations targeting the individual employee, recommendations that target psychosocial risk factors, and recommendations that promote positive protective factors). A maximum score of 14 was given to each document, with higher scores indicating higher comprehensiveness.

Analysis

A directed-content analysis approach was used to analyse the recommendations (Gisev et al., 2013). It was a directed approach in that we used the integrated framework as guidance for our coding scheme (LaMontagne et al., 2014). The percentage scores (Figure 1, Table 1) are based on counts of data that were averaged across each reviewer. Percentage scores were calculated, with a score of 14 indicating a guideline was 100% comprehensive. Table 1 depicts descriptive results of the content of included guidelines.

Quality Assessment

The Appraisal of Guidelines for Research and Evaluation (AGREE II) is a tool that has been validated to evaluate the guideline development process and quality of the recommendations in the guidelines (Brouwers et al., 2016). This rating instrument outlines 23 items across six key domains, including scope and purpose (3 items), stakeholder involvement (3 items), rigour of development (8 items), clarity of presentation (3 items), applicability (4 items), and editorial independence (2 items). Ratings were made on a 7-point Likert scale, where a score of 1 indicated 'strongly disgaree' and a score of 7 indicated 'strongly agree.' Higher overall scores indicated higher quality. Domain scores were calculated as per the following formula. These quality criteria are consistent with the IOM's definition of best practice guidelines.

> Domain score = (Total item scores – minimum possible score) / (maximum possible score – mimimum possible score) x 100

The AGREE II rating criteria does not include pre-defined cut off for ratings, but instead suggests raters agree on a cut-off for domain and overall scores prior to assessment (Brouwers et al., 2010). We adopted the Canadian academic evaluation cut-offs scores, and determined the overall score must be above 50% to be considered 'adequate' (Dewa et al., 2016).

Results

Description of Inclusion and Exclusion

Following the title review, 37 full-text guidelines were reviewed and 17 guidelines were excluded. The PRISMA flow chart (Figure 2) indicates the number of guidelines reviewed at each stage of the screening process and the reasons for exclusion (Moher et al., 2015). A list of excluded documents with reasons can be provided by the author on request.

Quality Assessment

Table 2 presents the results of the quality assessment. Following the quality assessment, only nine out of the 20 guidelines exceeded 50% score for rigour of development. Low scores in this domain were often due to a lack of information regarding the literature search. Of the 20 guidelines, seven scored <50% on stakeholder involvement, possibly due to a lack of reporting on this factor rather than a lack of consultation. Furthermore, 13 out of the 20 guidelines scored <50% in their applicability, indicating that many of the available guidelines did not include: advice and/or tools for employers to use to put the recommendations into practice; discussion of implementation of barriers and facilitators, or guidance on the resources required to implement the recommendations).

All guidelines scored >50% on the domain of scope and purpose. This indicates that all were sufficiently clear in describing the objectives and intended outcomes of the guidelines. However, it should be noted that it is was often ambiguous who the guideline was intended for. For example, particularly in relation to whether the recommendations were intended for small, medium, or large businesses. Six guidelines scored <50% for their clarity of presentation, suggesting that recommendations were at times not specific and therefore not always easily identifiable to the reader. Eight guidelines scored <50% on the editorial independence domain, indicating that almost half of the reviewed guidelines did not include an adequate discussion of any potential conflicts of interest, such as, how the funding body could have influenced the development of the guideline.

Comprehensiveness Scores

Table 1 and Figure 1 present the results of the content analysis. We identified four guidelines that scored >50% in their comprehensiveness. As described above, a score of 100% indicates that the guideline included recommendations at the primary, secondary, and tertiary level of intervention, as well as recommendations that were designed to target both individual, employee factors and organisational-level factors. To obtain a maximum score of 14, each of these key elements had to include practical tools and actions to implement the included recommendations. If the guideline included the recommendation, with no line of action, it only scored 1 on the respective element, and therefore could not score >50%. Guidelines scoring >50%, included one guideline from Canada (100%; Mental Health Commission of Canada, 2013), Australia (85.7%; Beyond Blue, 2013), the UK (71.4%; British Standards Association, 2009), and the EU (64.3%; Leka & Cox, 2016).

Five guidelines scored 50% (National Institute for Health and Care Excellence, 2009; Superfriend, 2013; WorkSafe Victoria, 2013; World Economic Forum Global Agenda Council, 2015; World Health Organisation, 2010). These guidelines addressed each of the key elements advocated in the integrated approach. However, these guidelines were only scored 1 on each of these elements as they failed to include practical tools to implement these recommendations. As shown in Table 1, scores <50% generally related to a lack of focus on the prevention of mental health problems. These guidelines tended to have a stronger focus on the detection and treatment of mental health problems within the workplace (e.g. Irish Business & Employers Confederation, 2012). Several lower scoring guidelines did include recommendations for prevention, however, because reccomendations were more targeted towards the individual employee and not organisational-level factors (e.g. Australian Human Rights Commission, 2010), they scored lower (see Table 1).

The variability in comprehensiveness scores both within countries and between countries was also noteworthy. For example, seven of the reviewed guidelines were published in Australia (Australian Government Comcare, 2008; Australian Human Rights Commission, 2010; Beyond Blue, 2013; Government of Western Australia, 2014; Our Consumer Place, 2014; Superfriend, 2013; WorkSafe Victoria, 2013). These guidelines had the highest variability, with comprehensiveness scores ranging from 28.6% - 85.7%% (see Table 1). High variability was also observed for the five guidelines published in the UK (Advisory Concilliation and

Arbitration Service, 2011; British Standards Association, 2009; Mind, 2013; Mindful Employer, 2014; National Institute for Health and Care Excellence, 2009), with comprehensiveness scores ranging from 35.7% - 71.4%% (see Table 1).

Discussion

While guidelines have been found to be an effective way to promote occupational health care their uptake is low (Hepner et al., 2007; Kennedy et al., 2010; Nieuwenhuijsen et al., 2003; Rebergen et al., 2010). Understanding the development and quality of guidelines is important to improving this uptake. The aim of this review was to assess both the quality and content of guidelines developed for use by employers to detect, prevent, and manage mental health conditions within the workplace (Hulshof & Hoenen, 2007). Our systematic review of the grey literature identified twenty guidelines. The Canadian Standard (2013) scored highest for both the quality and comprehensiveness of content. This was followed by the Australian Heads-Up material (Beyond Blue, 2013), the British Health and Safety Management Standards (British Standards Association, 2009), and the EU PRIMA-EF guideline (Leka & Cox, 2016).

The Canadian Standard (2013) was the only guideline that adhered to all levels of the integrated approach and included extensive guidance and practical tools for the implementation of recommendations at each of these levels. Several lower scoring guidelines (National Institute for Health and Care Excellence, 2009; Superfriend, 2013; Worksafe Victoria, 2013; World Health Organisation, 2010; World Economic Forum Global Agenda Council, 2015) also included reccomendations at each level of the integrated approach, but did not include practical tools for implementation and therefore could not score higher than 50%. Each of these guidelines scored highly in their rigour of development, with only applicability scores reducing their overall quality ratings. Therefore, we recommend that these guidelines be developed further to enhance their usability, or are used to inform the development of future guidance material.

It is also worth noting that several higher scoring guidelines were less comprehensive in content than several of the lower scoring guidelines. These guidelines scored higher, as although they had gaps in content, they included practical tools to implement the

reccomendations. For example, while the Heads-Up guidance material (Beyond Blue, 2013) included recommendations at the primary, secondary and tertiary levels of intervention and tools to implement reccomendations, these recommendations placed more emphasis on the individual employee, with less focus on organisational-level factors. This is in contrast to other lower scording guidelines that did emphasise both indvidual and organisational level factors (Worksafe Victoria, 2013; Superfriend, 2013). Evidence indicates that the most effective way to prevent, manage and protect employee mental health problems is via interventions designed to target both individual, employee-level and organisational-level factors (e.g. leadership styles, workplace climate or culture (Joyce et al., 2016; La Montagne et al., 2007, 2014). Therefore, we recommend that future guidelines be developed with consideration for organisational-level factors to ensure their recommendations are comprehensive and concordant with a best-practice, integrated approach.

A major gap in the Health and Safety Executive and the Prima- EF was the focus on minimising risk factors within the workplace. Although minimising risk factors is important and key to the prevention of workplace mental health problems, a fully comprehensive approach must also include recommendations that promote positive and protective factors within the workplace (La Montagne et al., 2014). Again, we recommend this is considered in the development of new guidance material (or revision of existing guidelines), in order to be a truly preventative approach.

This review suggests several other recommendations for the development and funding of future guidelines:

(1) Freely available and accessible information around the development process of the guideline and extensive stakeholder consultation during the development process
(2) Consistency of guidance material within regions
(3) Tools included for implementation are applicable to all business sizes e.g. not resource or time intensive
(4) The minimum, legal requirements within a region are made explicit to avoid confusion about what recommendations are legally required by a workplace and what are optional extras
(5) Consistency in language regarding mental health

1. Information about the Development Process

The purpose and aims were well described in each of the reviewed guidelines. However information around the development process was often missing, with 11 of the 20 guidelines scoring <50% in their rigour of development. Without this information it is difficult to ascertain whether the recommendations were based on up-to-date, quality evidence. Another area of weakness was the lack of stakeholder involvement, particularly consultation with the target population (i.e., employers). This consultation is integral to successful implementation, as the recommendations must be relevant for the intended audience. This may in part explain any low uptake of extant guidance material and as such represents an important consideration for the development of future guidelines.

2. Variability of Quality and Comprehensiveness

As depicted in Figure 1 and outlined in Tables 1 & 2, the reviewed documents varied greatly in their comprehensiveness and quality, with variation evident both within and between countries. Most of the guidelines reviewed were developed withinin Australia. However, despite this, the Australian guidelines exhibited the most variability in terms of both comprehensiveness and quality. Variability in quality and content was also observed in the United Kingdom. Although on face value having access to greater guidance material may appear beneficial, quantity does not necessarily translate to quality. The existence of multiple guidelines may also inadvertently act as as deterrant, as employers may not feel confident deciding which guidelines to adopt for their organisational context.

We suggest that one explanation for the greater number of guidelines developed within Australia and the United Kingdom, and the high variability across guidelines may relate to the fact that the United Kingdom and Australia currently has no national workplace mental health policy, or strategy. As such, there is no common understanding at a national level of what constitutes a mentally healthy workplace. We recognise that there are rigorous occupational health and safety laws in both Australia and the United Kingdom, which require that employers minimise workplace psychosocial risk for employees, these are legal frameworks and only reflect one thread of the integrated, best-practice approach (La

Montagne et al., 2014). Conversely, Canada, through a concerted effort to engage a wide range of stakeholders, has developed a well-researched 'standard' for workplace mental health that incorporates established procedures, largely accepted by employers (Kalef et al., 2016). This unified, rigorous development approach likely explains the consistency and high quality of guidance material developed from Canada (Mental Health Commission of Canada, 2013).

3. Implementation

Another consistent gap found in the reviewed guidelines related to implementation. Many of the guidelines did not provide additional tools to assist with the implementation of guideline recommendations, and if they did, these were often time and resource intensive or required additional training to implement. Recommendations were often not appropriate for small-medium businesses that do not have the time, money, or confidence to implement resource-intensive interventions, or the staff with expertise and roles intended for this purpose (Martin et al., 2009) and few of the guidelines identified as being relevant for workplaces of differing sizes (small, medium or large). The Canadian Standard does this well (Mental Health Commission of Canada, 2013), as the varying needs of different size businesses are explicitly outlined through the use of case studies. These practical examples may result in increased uptake, as businesses may feel more confident to implement the recommendations.

4. Legal Requirements and Additional Extras

Another major shortcoming was a lack of explanation regarding which recommendations are legally mandated for a region, and which are 'optional actions.' Without clear direction regarding employer responsibilities many employers may unknowingly neglect their legal responsibilities. The Canadian Standard explicitly outlines the legal obligations of employers, specifying what employers 'shall do' (i.e., a legal requirement), 'should do' (i.e., advised, but not legally required), and 'may do' (i.e., optional) (Mental Health Commission of Canada, 2013). State-based jurisdictions, such as in Australia, may face some regional challenges to adopting a national framework, however, Canada's laws similarly vary by province and these minimum requirements are still broadly addressed within the Canadian Standard.

5. Language Regarding Mental Health

This use of explicit and deliberate language also highlights another key issue. For example, in many of the Australian guidelines the terms ‘psychological health’, ‘mental health’, and ‘mental illness’ were used interchangeably. Consistent use of terminology is important to avoid misinterpretation by the various professionals involved in workplace mental health (e.g. medical specialist, employer, human resources manager). The term ‘mental illness’ is associated with a disease state and its use in non-clinical situations may direct attention toward a treatment approach only. The Canadian standard consistently and deliberately uses the terms ‘psychological health and safety’ and defines this at the outset. It is suggested that future developers clearly define and justify the language used.

Limitations of this Study

A limitation of this review was that literature searches were limited to documents published in English. Because our search strategy was iterative, there may have been guidelines that were not identified by the search terms. However, we conducted extensive manual searching and consultation with experts and therefore we are confident that all guidelines that met our inclusion criteria have been considered in this review.

Implications

This work has several implications for a range of stakeholders. First, we anticipate it will help researchers and policy-makers translate evidence of best practice into usable recommendations that help employers build mentally healthy workplaces. Second, employers can use these findings to direct them towards examples of best-practice relevant to them. It is anticipated this review may broadly help increase the creation and uptake of good quality guidelines and recommendations, as employers may feel more confident in adopting approaches that have been evaluated as best-practice.

Our recommendations may also have implications for policy development, as they provide evidence of best practice that may inform the development of a national framework for workplace mental health. Although we only included English-language guidelines in this

review, we found none that were published from developing countries, highlighting a gap in available guidance material on the prevention, treatment, or management of mental health conditions (Atilola, 2012; Chopra, 2009; Idris et al., 2011). This review could be used to help inform all relevant stakeholders in developing countries how to develop well researched, high quality guidance material to help prevent work-related mental health problems in these countries.

Conclusion

We identified twenty guidelines developed for employers to help prevent, manage, and detect mental health problems within the workplace. The content and quality of guidelines varied significantly, with low scores often due to a focus on the detection and treatment of mental health problems in the workplace rather than on protection and prevention. When guidelines did include recommendations for prevention these were often individually focused or did not include practical tools or advice to implement. Over all, the guideline development processes lacked rigour and stakeholder consultation was a frequent weakness. It is suggested that these factors be considered in the development of future guidelines, to improve uptake, commitment and implementation, and thereby assist efforts to build mentally healthy workplaces.

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