Taking the First Step towards Entrenching Mental Health in the Workplace: Insights from a Pilot Study Among HR Personnel in Nigeria

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ABSTRACT

BACKGROUND: The continued relevance of optimal employee mental health to sustainable human capital development in the workplace underscores the need to start harnessing all resources that can be mobilized to promote the entrenchment of workplace mental health. The strategic place of workplace Human Resource (HR) units in formulating and implementing workplace welfare schemes makes them potential partners. To actualize this, it is important to initially assess the preparedness of HR personnel for, and the possible barriers to entrenching mental health in the workplace. To suggest the initial course of action and to serve as a template for a robust large-scale study, we conduct a pilot assessment of the experience with, attitudes towards, and level of prioritization of mental health in the workplace among a cohort of HR personnel in Nigeria.

METHODS: Participants were recruited in the course of a seminar/workshop and questionnaires were developed by authors to assess variables of interest. Attitudes were examined using an adapted form of the Link's Discrimination-Devaluation (LD-D) scale.

RESULTS: A total of 90 human-resource personnel completed the questionnaires. Only 16% of the participants reported having handled the case of an employee with a suspected mental health problem in the preceding 2 years. Attitudes toward employees and prospective employees with mental illness were largely poor. For instance, more than 70% were likely to consider for employment someone with a pre-existing physical disability than for someone with a history of mental illness. In terms of workplace health promotion priorities, physical health seminars took wide precedence over mental health seminars.

CONCLUSION: The preliminary findings of this pilot study justify a need to conduct a large scale study. Significant challenges encountered in the course of this pilot study were highlighted while insights were drawn for the conduct of the main study/project.

KEY WORDS: mental health, occupational health, workplace, HR personnel, attitudes

INTRODUCTION

Beyond the often preferentially emphasized physical well-being of workers; contemporary frameworks for Occupational Health and Safety (OHS) emphasize equal attention to the physical, social and mental aspects of work in the workplace. This paradigm shift has engendered a global shift of attention to the prevention, recognition and reduction of mental health risks in the workplace.[1,2] This new focus of attention is premised upon the recognition that at a scale higher than that which is attributable to physical health problems, unmitigated and unattended mental health problems can affect productivity in the workplace.[3-5] The industrialized countries of the world had taken advantage of such insights to invest heavily in primary occupational mental health with documented evidence of attendant positive accruals to workplace productivity and human capital development.[6-8]

Unfortunately, the developing countries- especially in the region of sub-Saharan Africa- are yet to evolve a coherent and sustainable framework for promoting and attending to mental health issues in the workplace.[9] While it is understandable that the

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competing interests for lean resources in developing countries limits the scope and depth of any welfare scheme, occupational health issues of any kind is too critical to be neglected. This is in view of the expectation that the precarious nature of work in resource-constrained regions like sub-Saharan Africa dictates a higher risk of mental stress in the workplace as well as a more profound effect of poor mental health of workers on productivity. Continued erosion on the health of the labor force and productivity can hinder sustainable economic development in such regions.

There is therefore an urgent need to start harnessing the resources that can serve as springboard for the entrenchment of occupational mental health in developing regions of the world. Other than professionals in mental health and allied professionals, the Human Resource (HR) units in the workplace are among the strategic potential partners in the formulation of occupational mental health policies. This is because, the HR unit is often charged with the responsibility of managing the human capital of the establishment, including formulation and implementation of policies on employees' welfare and wellbeing. Therefore, as a first step towards entrenching occupational mental health in any country, it is pertinent to examine the familiarity with and attitudes towards mental health issues among HR personnel. It is equally important to assess the place of mental health in the current framework for employee welfare scheme in Nigerian workplaces.

Nigeria has an estimated workforce of about 50 million,[10] thus accounts for the largest workforce on the African continent. Research into the status of occupational mental health is not yet a priority in the country. Therefore, this study aims to conduct a pilot assessment of the attitude of HR staff in some workplaces in Nigeria towards workplace mental health issues and to assess the place of mental health in the current employee welfare practices of the establishment. The information gathered in this study can set the tone for the initial attitudinal interventions needed as groundwork for the entrenchment of occupational mental health in the country. More importantly, it can also serve as template for a large-scale study that can inform policy development and serve as an advocacy tool in this field.

METHODS

Participants and mode of recruitment: Participants were drawn from the attendees of a seminar/workshop organized by a consulting firm in Lagos Nigeria for HR personnel. The participants were invited to participate in the workshop/seminar focusing on the implications of the newly promulgated Nigeria Employee Compensation Act for human resource management in the country. The invitation was through registered mail to the HR unit or the Chief Management personnel of public and private employers of labour listed in the Nigerian Directory of Businesses. The mail invitation was structured to include all the major sectors of employment in Nigeria including public service; agriculture, aviation, automobile, breweries, building materials, banking and finance, conglomerates, construction, food/beverages and healthcare sectors. Other sectors that were invited by registered mail included hotel and tourism, legal services, educational, maritime, oil and gas/engineering, telecommunications, and real estate sectors. The registered mails were augmented with a half-page advertorial in a major national daily as an open invitation to all sectors. The courier companies gave evidence of delivery. The venue of the 2-day workshop/seminar was a major international hotel in Lagos.

Since the organizers were private organizations and were not able to secure funding for the project, a fee of 70,000 Naira (approximately 400 USD) was charged per participants to cover costs which included logistics (mailing, service charges, and support staff, feeding) and honoraria for speakers. Authors OA and BA served as resource persons in the workshop/seminar. The organizers of the seminar/workshop asked all intending participants to register their intention to participate and show evidence of payment on a webpage. In anticipation of a low response rate, authors selected a random sample of 25 companies that received invitation by courier, but which did not register intention to participate in the seminar/workshop as at the last day prior to the program. Telephone calls and/or e-mails (gotten from the Directory) were made or sent- as the case may be- to these companies to enquire about the most important reason why they would not participate. The head of HR unit or a designated staff of the unit

were the recipients of the phone call/e-mails. Their responses were documented.

Procedure and Questionnaires: Written informed consent to participate in the study was sought from all participants that attended the seminar/workshop. Consenting participants were requested to fill a 33-item questionnaire designed by the authors. The time taken to complete questionnaires was noted. The questionnaire comprised of 5 sections designated A to E. Section A was designed to obtain basic bio-data, the nature of organization, designation et cetera. Section B examines participants' previous experience with mental health outside the workplace. Examples of questions under this section include having a family member who has or had had a mental disorder and whether participants had ever been involved in the care of someone with mental disorder outside of his/her current workplace. In section C, participants' previous experience with mental health within the workplace was examined by asking- among other questions- if participants' had had to handle the case of an employee with a suspected mental health problem or to refer an employee for mental health evaluation in the preceding 2 years. Section D examined the place of mental health in the current employee-welfare framework of the company.

Section E examines the attitudes of respondents towards mental health in the workplace along the domains of pre- and post-employment discrimination and social distance. The modified version of Link's Discrimination-Devaluation scale[11] was used as the template to design the attitudinal questionnaire. The Link's Discrimination-Devaluation (LD-D) scale questionnaire has 12-items consisting of 6 statements on social-distance from patients with mental illness and another 6 statements on discrimination of patients who had had mental illness in the past. Though not among HR personnel, the LD-D scale had been used among other professionals to assess attitude to individuals with mental illness in at least one study in Nigeria.[12] The questions in the LD-D scale were modified and operationalized into formats that can assess workplace related issues. The resultant 9-item questionnaire was designed such that response-options were in a 5-option Likert scale which ranged from 'strongly agree' through 'undecided' to 'strongly disagree'. As an addendum to section E; participants were asked to prioritize a list of considerations that can serve as a barrier- in their respective workplaces -to employing someone who had had a mental disorder in the past. There were five possible considerations pre-listed in this sub-section; respondents were to score the most important consideration '5' and the least '1'.

Statistical analysis: The data collected were analyzed using the Statistical Package for Social Sciences version 16 (SPSS – 16) software. Descriptive statistics (frequency) was used to describe the socio-demographic characteristics and the experience of respondents with mental health issues within and outside the workplace. Familiarity of respondents about workplace mental health issues were also presented in a frequency table. For the attitude section, attitude was rated positive if the response is in support of mental health promotion and non-discrimination. A score of 5 or 4 in the 'positive' direction on the Likert scale was taken as suggestive of positive attitude while scores 3, 2 or 1 were taken as negative attitude. Overall attitude was measured using the total average score.

RESULTS

Participants: The consulting firm that organized the seminar/workshop which served as the setting of the study sent out invitations to a total of 348 companies within our own study time-frame. A total of 66 companies responded by registering their intentions while 64 eventually attended the seminars, giving a final response rate of 18.4%. All attendees of the seminar agreed to participate and gave consent for interview. A total of 90 respondents completed the questionnaires (some companies sent more than one participant) with a mean of 1.4 ± 0.3 participant per company. The mean time taken to complete questionnaires was 17 ± 4 minutes (range 15 – 22 minutes). The 25 non-responders that were contacted turned out to constitute 9% of total non-responders. Twenty-four (96%) of all non-responders agreed that the issues to be discussed at the seminar/workshop were relevant and important. The 'most important' reasons given by the companies' representative for not participating were 'financial implications' (n = 19; 76%); operational challenges of other responsibilities for would-be attendees (n = 4; 16%) and 'other logistic

reasons' (n = 2; 8%). As shown in table 1, participants were mostly males (57.8%) in their middle ages. They were mostly (62.2%) in managerial cadres with a mean HR-management experience of 7.0 ± 5.8 years. The participating companies were mostly drawn from big corporations like oil and gas/engineering (64.4%) and finance (23.3%) sectors.

Previous experience with and prioritization of mental health issues: Table 2 & 3 shows the previous experiences of participants with mental illness within and outside the workplace. Training on workplace safety and retirement planning were the most common seminar/workshops that respondents had recommended for their respective companies (see table 4). Stress management seminar was also fairly popular but seminar/workshops focusing directly on mental health in the workplace came a distant last on the priorities of respondents.

Attitudes towards mental health issues: Overall, 48 (53.3%) of respondents gave responses that reflects negative attitude towards mental health issues in the workplace. Discriminating attitudes towards prospective employees with a history of mental illness was common as 72.2% (n = 65) of respondents will rather consider for employment someone with a preexisting physical disability than for someone with a history of mental illness. Social distance from an employee with a history of mental illness was also common as 73.3% (n = 66) of respondents were unwilling to share same office with someone with a history of mental illness. Further details of responses to questions assessing respondents' attitudes towards mental illness in the workplace are shown in table 5a. In another attitudinal dimension, the overall most important consideration among respondents when contemplating recommending the employment of someone with a history of mental illness was workplace safety while the least was the financial burden of possible inter-current treatment or care (see table 5b).

Table 1 Socio-demographic characteristics of respondents (N=90)

Variable	Frequency	Percentage
Age (years)		
<40	25	27.8
40-49	55	61.1
=50	10	11.1
Mean±SD	41.3±6.7	
Sex		
Male	52	57.8
Female	38	42.2
Marital status		
Single	33	36.6
Married	57	63.3
Religion		
Christianity	79	87.8
Islam	11	12.2
Industry		
Oil & Gas/Engineering	58	64.4
Finance	21	23.3
Others*	11	12.3
Current work designation		
Management level	56	62.2
Below management level	34	37.8
Experience in HR (years)		
<10	70	77.8
10-19	16	17.8
=20	4	4.4

*Media, Hospitality, Legal, and Educational sectors

Table 2 Previous experiences with mental health outside the workplace (n=90)

Variable	N (%)
Have you ever thought you might need some mental health evaluation?	16 (17.8)
Do you know of a member of your extended family who has/had any form of mental disorder	20 (22.2)
Do you know of a member of your extended family whom you have reasons to suspect may need mental health evaluation	21 (23.3)
Have you been involved in arranging for the care/treatment of a family member(including extended family) with any form of mental disorder	12 (13.3)
Do you have a member of your extended family or a friend of yours who is a psychiatrist or in any allied mental health profession?	9 (10.0)

Table 3 Previous experiences with mental health within the workplace

Variable	N (%)
Have you had to handle the case of any employee with a suspected mental health problem in the past 2 years?	17 (18.9)
Have you had to refer an employee for mental health evaluation or treatment in the past 2 years	14 (15.6)
Have you ever had to recommend early retirement with benefits (compensation) for an employee on account of mental disability which developed on the job	7 (7.8)
Have you ever had to recommend the sacking of an employee on account of mental disability which developed on the job?	3 (3.3)

Table 4 Training programmes/seminars respondents had recommended for the company in the past year

Variable	N (%)
Workplace safety training course	80 (88.9)
Stress management seminar	49 (54.4)
Mental health in workplace seminar	6 (6.7)
Retirement seminar	57 (63.3)

Table 5a Attitude towards mental health issues in the workplace

Attitude	Positive n (%)	Negative n (%)
Discrimination at work and in workplace policies		
Persons receiving treatment for mental illness can work regular jobs	55 (61.1)	35 (38.9)
Persons who are returning to work after treatment for a mental disorder with full recovery should not be allowed back to their previous position or post, they should be given lesser responsibilities or increased supervision	49 (54.4)	41 (45.6)
It is more appropriate to recommend compensation for an employee with a physical injury than for mental/psychological trauma	54 (60.0)	36 (40.0)
It is more appropriate to seek medical help for an employee with physical health problems than for mental health problems	66 (73.3)	24 (26.7)
I will rather consider for employment someone with a preexisting physical disability than for someone with a history of mental illness	25 (27.8)	65 (72.2)
Social distance at work and workplace policies		
I will be comfortable working on the same job with someone with a history of mental illness	40 (44.4)	50 (55.6)
I will feel comfortable to share my office with someone with a physical disability than someone with a history of mental illness	30 (33.3)	66 (73.3)
I will rather socialize with a physically disabled than with someone with a history of mental illness	30 (33.3)	60 (66.7)
I will be willing to recommend mental health education for employees in my company	61 (67.8)	29 (32.2)

Table 5b Considerations in recommending the employment of someone respondents knew had a history of any form of mental disorder (ordered according to respondents' scoring on a scale of 1 to 5).

Variables	Mean score	Scores in % terms
Workplace safety	4.26	85.2%
Productivity at work	3.43	68.6%
Reaction of other employees	2.84	56.8%
Company's image	2.64	52.8%
Financial burden of possible inter-current treatment or care	1.84	36.8%

DISCUSSION

This study seized the opportunity of a seminar/workshop organized for HR managers to assess for their attitudes towards and priorities when it comes to mental health issues in the workplace. The study is essentially a pilot study with a view to design a larger-scale study. Therefore, the focus of this discussion is to briefly comment on some interesting findings and to harness the insights gained from this study in the design of a large-scale descriptive/interventional study which can serve as a major template towards the entrenchment of occupational mental health in Nigeria.

Key among the interesting findings of the current pilot is the observation that the experience of participants with mental health problems- either within or outside of the workplace- is limited. And that mental health featured lower in the priorities of welfare-related training seminars/workshops in the workplace. In addition, attitudes towards mental health in the workplace were largely negative; while workplace safety and productivity concerns were the leading factors that may drive pre-employment discrimination of someone with history of a mental illness in respondents' workplaces. Drawing profound conclusions from this study will not be appropriate in view of the fact that it a pilot study, and the response rate was too low and too skewed towards some sectors of the economy to allow for generalization of findings.

However, the findings of the study are potential areas that a large-scale study need explore. This is especially correct in view of the fact that the findings are not counter-intuitive and share some similarities with recent studies from Nigeria. In a region like Nigeria where public knowledge of; and attitudes towards mental health issues is poor,[13,14] it is not unexpected that HR personnel- who are just another member of the lay public- will have similar perception of the issue. Also, an earlier small-scale study among HR managers in Port Harcourt (Nigeria) showed that less than half of respondents endorsed mental health services like counseling and other psychological interventions as a veritable means of promoting a healthy workplace.[15]

The present pilot study however provides some insights that can improve the value and utility of the main study. The continued salience of occupational mental health in the quest for sustainable human and industrial capacity development in any region underscores the need to develop the capacity of workplaces to pre-empt, recognize and address work-related mental health risks. Therefore, just like it is the case in the present pilot study, it will be advisable that the large-scale study have both descriptive and interventional components. The descriptive part should build on the design of the current pilot study while the interventional part should incorporate a seminar/workshop for the participants.

The forum for the current pilot study was a seminar/workshop focusing on certain aspects of a newly promulgated labour law and it was the attraction through which participants were recruited. Hence, the large-scale can be integrated into an interventional seminar/workshops organized for HR personnel, focusing on enhancing the capacity for

occupational mental health in workplaces. The content of such seminar/workshop should include training on an overview of signs and symptoms of common mental health problems in the workplace and its implication for productivity. It should include how to pre-empt and prevent work-related mental health problems; how to seek professional help for employees with work-related mental health problems, and on how to formulate a workplace mental health policy and establish a psycho-social support unit in the workplace. In view of the recent enactment and signing of Nigeria's Employee Compensation Act of 2010[16] which made a distinct provision for compensation for disabling work-related psychological trauma; it will be imperative to also include training on how to seek compensation for employees under such provision in the Act in the programmes of the seminar/workshop.

Addressing these important issues in the seminar/workshop will be in line with the thinking that the workplace is a potential setting for mental health education and creation of awareness about mental health problems, as well as a viable setting for early recognition and treatment of mental health problems.[17] Such seminar/workshop has the potential of opening up the issue of mental health in the workplace among HR personnel in the country, and could serve as a template for further engagement. To ensure representativeness in terms of spread, the seminars should hold in a capital city in all the six geo-political zones. This should be in addition to two dedicated seminar/workshops in Lagos and Abuja being the economic and political capitals respectively for the country and with the highest density of employers and employees. Resource persons for the seminar can be drawn from a team of experts in public mental health, occupational mental health, and industrial psychology. These can be sourced from the academia and organized consulting firms. HR personnel drawn through the same method as in the present pilot study can then be invited to participate in the seminar/workshop.

However, the idea of incorporating a seminar/workshop into the main project- while very innovative and insightful- raises other concerns that need to be addressed. Key among these concerns is the issue of funding. Though the private consulting firm that organized the present pilot seminar/workshop did not provide us with the full details of the costs, it is obvious that there will be a need to cover the costs of hotel accommodation, transportation and honoraria for resource persons; service charges at the venue, and at least tea/lunch for all participants. The services of a consulting firm which can provide logistics services like mobilization, courier services, paper-work, and other secretarial services may also have to be factored in. The problem of low response rate is another challenge that must be addressed if the results of the main study were to be relevant for policy formulation. From the results of the current pilot study- in spite of the apparently low response rate- it is clear to some extent that work establishments may not be averse to participating in seminar/workshops that addresses how to improve employee wellbeing; but that cost may constitute a significant barrier. The fact that most of the participants that eventually attended the pilot seminar/workshop were from the big corporations with good financial strength (e.g. oil and gas, engineering and finance sectors) supports the view that the cost of attendance may be a barrier. This is further confirmed by the observation that most of the non-respondents gave financial considerations as the most significant de-motivating factor that militated against their expressed wish to participate in the seminar/workshop.

Financial considerations as a barrier did not however come as a surprise since majority of workplaces in the sub-Saharan Africa region often battle a lot of challenges that affects their productivity which then dictates that they cut their spending- particularly employee welfare related spending.[9] Therefore, in conducting the main study, it will be pertinent to seek funding to cover the costs of the project so as to be able to defray most or all costs to would-be participants. We speculate that the turn-out for the pilot seminar/workshop would have been significantly higher if there were no fees attached. This is however premised on the assumption that unwillingness to expend resources on employee welfare-related seminar/workshop was borne out of resource limitation and not nonchalance. This can only be confirmed in retrospect after the execution of the main project.

Equally important is the need to use the forum provided by the seminar/workshop to identify

possible barriers to the entrenchment of occupational mental health in the country. The present pilot study can then be replicated at the beginning of the seminars/workshops. However, some aspects of the questionnaires used in the pilot study may need amendements to improve the accuracy of the findings. For instance, with benefit of hindsight, it may have been more appropriate to access the familiarity of participants with mental illness by providing case vignettes of common work-related and other mental disorders like depression, posttraumatic stress disorders, generalized anxiety disorders, substance use disorders and psychosis. A clearer picture of the familiarity of respondents with mental illness may have been obtained by asking them questions in reference to the case vignettes rather than the often vague concept like 'mental illness'. In the same vein, the attitudinal questions may also need to be asked in relation to the case vignettes rather than the general term 'someone with mental illness' to improve context appropriateness. These changes may need to be incorporated into the main study. Doing all these may increase the time of administration of the questionnaire but should still be within 45 minutes.

In the final analysis, demographic and workplace factors that were independently associated with workplace employee welfare priorities as well as attitudes towards mental health in the workplace can then be tested in a logistic regression model. This is premised on the hope of a larger and more representative sample size. The independent factors can then constitute intervention points in policies designed to reduce stigma of mental illness in the workplace and generally to design strategies to improve the acceptance of mental health promotion in employee welfare schemes.

CONCLUSION

The preliminary findings of this pilot study justify a need to conduct a large scale study- in terms of participants' spread and the depth of the interview- from which profound conclusions can be made. Incorporating an intervention program into the main study will ensure optimal utilization of the huge cost that is likely to be incurred in the course of the main study. While the authors of the present paper are hoping to seek the kind of funding necessary for this important project, it is imperative that we document the findings of this pilot project as well as our thoughts about the feasibility, methodological framework and the relevance of the main project if and when executed. It is hoped that other researchers and labor policy advisers in Nigeria, and indeed other sub-Saharan African countries, may find the insights provided in this pilot study useful in their quests for the entrenchment of occupational mental health in the region.

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