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Potential enablers of mental health and wellness for those teaching in tertiary education

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The mental health and wellness of those teaching in Australian universities is in the spotlight. The role of teaching academics in contemporary universities is reported to be in a state of transition, moving from traditional teaching, research and management responsibilities, to more differentiated duties including management of casual staff, accreditation and administration tasks (Bennett, Roberts, Ananthram, & Broughton, 2018; Chory & Offstein, 2017). Stress of heavy workloads, performance demands with fewer resources, expansion of staff roles and expectations, higher research productivity and output expectations are the common neoliberal pressures grounded in commodification and globalising marketisation of knowledge in higher education settings (Field, 2018; Kinman & Wray, 2018). Such examples of neoliberal processes have been well documented, however, Dudau, Kominis, and Szocs (2018, p. 254) contend, although decreasing funding and resources brings pressure, it also invites opportunity for innovation and creativity and "identifying newer, more effective products or services, using technological advances more effectively, streamlining processes, and so on". Additionally, for Barnett (2018), contemporary universities are uniquely positioned to embrace possibilities and change. This positioning may encompass cultivating sustainable health-promoting cultures with a focus on promoting high levels of employee mental health and wellbeing through initiatives including enhancing mental health literacy. Therefore, this paper explores the literature in alignment to the research question, 'what are potential enablers of mental health and wellness for those teaching in tertiary education?'.

Background

Mental health has been defined by the World Health Organization (WHO) (2001, p. 1) as "a state of well-being in which the individual realises his or her abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". Mental health can vary in severity, within an individual over time, and between individuals. Several domains of daily life can be impacted or a person's whole life can be inflicted by mental health problems. Good mental health has been conceptualised as a state of well-being where the individual realises personal abilities, can handle and be responsive to changing societal contexts (Stallman, 2011), has the ability to positively adapt / cope with adversity, and /or significant life stressors. A closer examination of the resilience literature indicates that optimism, self-care and kindness remain foundational for building resilience (Hofmeyer et al., 2018; Kim, Park, & Peterson, 2011) and that "wellness is the result of our conscious commitment to a way of life that leads to zest, peace, vitality, and happiness" (Corey, 2017, p. 34)

Having a sense of purpose in life is linked with higher levels of psychological well-being and physical health (Plotnikoff et al., 2015; Roberts, 2018), and is very beneficial in times of distress and loss (Frankl, 1984). Today, many teaching academics are challenged to respond to their constructive discontent, an inner urging to seek more effectiveness with their teaching and learning, even though what they are doing is effective. As McArdle (2013, p. 11) explains, "constructive discontent is the life blood of the quality teacher and produces the 'fire in the belly' for continuous improvement in effectiveness. Empowerment focused teaching academics are challenged to identify what is meaningful as they develop, change, transform and grow to remain highly effective in our ever-changing higher education world." When work is meaningful and purposeful, there is often a sense of contribution; a belief that one's work is making a difference in the workplace and perhaps the wider community.

With around one third of university students failing to complete their studies within 6 years (Nation of dropouts published by news.com.au 27.1. 2017), and the growing prevalence of students experiencing serious and complex mental ill-health, teaching academics and professional staff are working in an increasingly demanding, challenging and emotionally taxing work context. The National Union of Students, with the support of headspace: National Youth Mental Health Foundation 2016 study of Australian university and TAFE students (n= 3303), reported

approximately two-thirds of students in the past 12 months, reporting high or very high psychological distress. The two most common study related factors affecting mental health were balancing study and other commitments (76.8%) and workload and deadlines (79.5%) (Rickwood, Telford, O'Sullivan, Crisp, & Magyar, 2016).

It is within this context of high levels of student mental ill-health, stress of heavy workloads, performance demands with fewer resources, expansion of staff roles and expectations, higher research productivity and output expectations, that the common neoliberal pressures grounded in commodification and marketisation of knowledge in higher education settings exist (Field, 2018; Kinman & Wray, 2018; Orman, 2017; Orygen, 2017; Veness, 2016, 2017). Within this environment many teaching academics report high incidence of job stress related to work overload and work-life imbalance (Lorenz, 2012; Plotnikoff et al., 2015). Furthermore, Bell, Rajendran, and Theiler (2012) report teaching academics experience higher rates of stress (on average) than other staff working in universities. Characterized by mental and physical exhaustion, a sense of ineffectiveness and negligible achievement (Spickard, Gabbe, & Christensen, 2002), and detachment from work, job stress negatively impacts mental health and is closely correlated with reduced work performance and poor decision making (Jansson & Gunnarsson, 2018; Jeon & Kim, 2018). This landscape is complicated by job security issues including uncertainty about future contracts and disparities with superannuation contributions (Rabaut, 2017). There are more than two-thirds of university teaching staff employed in different ways, "on average, 43% of all university employees are employed on a casual basis, another 22% employed on limited fixed term contracts and only about 35% employed on a permanent or tendril basis" (Kniest, 2018, p. 3).

Moving beyond higher education, with mental ill-health being a silent phenomenon in working life (De Lorenzo, 2013), poor employee mental health has been associated with lack of workplace democracy (Rea, 2018), frequent absenteeism, reduced motivation and productivity (presentism) (Ashman & Gibson, 2010; Jansson & Gunnarsson, 2018), increased errors, poor interpersonal relationships (Shain, Arnold, & GermAnn, 2012), and reduced productivity (Lloyd, King, & Chenoweth, 2002). Consequently, mental illness is "responsible for a very significant loss of potential labour supply, high rates of unemployment, and a high incidence of sickness absence and reduced productivity at work" (OECD, 2012, p. 11). In fact, Safe Work Australia estimates the economic burden of poor psychological health costs Australian organisations $543 million per

annum in workers' compensation for work-related mental health conditions (Safe Work Australia, 2018a).

System level responses from the *top*

With universities having a duty of care to their staff, there is scope for a better understanding of potential enablers of mental health in higher education settings. According to Safe Work Australia (2018b, p. 20) a systematic "best practice approach to developing and sustaining a psychologically healthy and safe workplace should focus on mental illness prevention and mental health promotion", preventing harm, early intervention, and supporting recovery. Such a holistic, systematic approach is important, as Killackey (2017, p. 9) explains, "recovery from mental illness involves much more than recovery from the illness itself… [and] is often a complex, time-consuming process" and involves factors, such as: overcoming stigma, working through treatments and experiencing possible unemployment.

In line with the 2017 Australian government response to the Higher Education Standards Panel (2017, p. 7) final report – *Improving retention, completion and success in higher education* state, "every institution should have an institution-wide mental health strategy and implementation plan". Hickie's (2018) Australasian Mental Health and Higher Education Conference (AMHHEC) keynote address *Developing the 'Mental Wealth' of Australian Youth Attending Higher Education* rationalised growing mental wealth is an institutional-level responsibility in the 21st Century. Australian Institutions such as The Australian National University, The University of Melbourne and the University of Canberra already have whole of university approaches promoting mental health and wellbeing for students and staff. Formulating institutional responses that move beyond duty of care, targeting places of transition (entry to higher education and exit to workforce) and partnership and not paternalism, Hickie pondered mental health awareness, self-management competency, personal responsibility, and organisational planning, policy and action, identifying more personalised staged care regimes through designated services (e.g., headspace) and evidence informed e-health platforms (e.g., Made4me; Mood gym; Head the Health; reach Out Next Step) as the way of the future to grow the mental wealth of individuals and institutions. Emphasising that responsibility for mental health and wellness promotion in universities, needs to include the government, institutional, health professionals, community groups, and individuals, Hickie (2018) defined access and quality as the genuine challenges in mental health service provision, and

specified new technologies of scale as integral to planned approaches to holistic, person-centred mental health promotion, prevention and early intervention.

In the context of higher education, mental ill health of academics affects the performance of others working in academia as well as negatively impacting student outcomes (Bell et al., 2012). As Aarons and Sawitzky (2006) argue, the climate and culture of an organisation can influence the mental health of staff, their work ability, and their uptake and adoption of mental health promoting policies and practices. Consequently, it seems imperative that employers develop and enact policies, practices and processes that both protect and promote the mental health of staff thus leading to improved working conditions, increases in productivity in the workplace, and higher levels of employee wellbeing (LaMontagne et al., 2014).

In a pertinent study by Zábrodská, Mudrák, Květon, Machovcová, and Šolcová (2016), examining the quality of academic work life in Czecz public universities (n=2229), 83.6% of respondents reported high levels of job satisfaction, and 13.7% relatively low levels of stress. Many reported positive aspects in their work environments (e.g., autonomy, role clarity, commitment to the workplace, and high or very high social support from their colleagues (41.6%). Despite the high levels of job satisfaction, findings suggested drivers of dissatisfaction are salaries, academic leadership, and pressure to produce, supporting the notion of institutional reforms to the Czech system of public university governance.

Staying with public universities in the Czech Republic, Mudrak (2017) (n=1389), implemented the Job Demands-Resources (JDR) structural equation model, to explore the relationships between academic work environments (perceived job resources - influence over work, support from colleagues and supervisors; and job demands - job insecurity, work-family conflicts, and perceived ability to handle emerging tasks), and different dimensions of faculty well-being (job satisfaction, stress and work engagement). Job resources were found to be predominately related to work environments; and job satisfaction was associated, almost exclusively, with stress. Job demands related to the exhaustion of psychological resources (mostly through work-family conflict), led to high levels of experienced stress, even when academics were engaged and satisfied with their work and jobs respectively. In line with Zábrodská et al. (2016), the majority of academics in this research considered the quality of academic leadership at the institutional level needed attention. The literature emphasises the pivotal role of leadership at all levels in creating

and nurturing positive supportive workplace cultures reflective in organisational policies and processes; environments that are accepting of mental health problems and open to communicating about and attending to workplace concerns, in conjunction with providing wellness resources and health promotion programs (Dimoff, Kelloway, & Burnstein, 2016; Dimoff & Kelloway, 2018a, 2018b; Hall, Bergman, & Nivens, 2014).

An issue arises however, with mental health being highly stigmatised, many employees are reluctant to seek assistance from employers or / and access workplace wellness interventions and resources (Auten & Fritz, 2018; Malachowski, Boydell, & Kirsh, 2018; Sivris & Leka, 2015). In the same vein, many leaders and managers have not attended mental health training and / or are unaware and / or misinformed about mental illness. They habitually express apprehension in responding to employees who present with difficulties coping in the workplace (Dimoff & Kelloway, 2018a; Hobfoll, 2011; Margrove, Gustowska, & Grove, 2014). Complications in a system-wide response to the hidden epidemic of mental ill-health (De Lorenzo, 2013) include no established policies or practices to support employers in dealing with non-disclosed mental illness. This is a conundrum with many managers and human resource staff unaware of the prevalence of mental illness in their workplace, with large numbers of employees choosing to conceal mental ill-health primarily because of perceived stigma, shame and potential for discrimination (Corrigan, Janessa, & Shapiro, 2010; Rüsch, Corrigan, Todd, & Bodenhausen, 2010).

Within this context there is a need for employers to develop, monitor and enact policies, practices and processes that cultivate sustainable health-promoting cultures with high levels of employee wellbeing. Mental Health Literacy (MHL) is proposed in the literature as a plausible action to endorse, thus providing learning opportunities for staff to advance their knowledge and understanding of mental health and wellness (Woloshyn & Savage, 2018), in conjunction with "the recognition, treatment, rehabilitation, and return to work of working people affected by mental disorder" (LaMontagne et al., 2014, p. 6). Ideally, such mental health promotion and prevention needs "to be executed with fidelity, be targeted to multiple levels of functioning, have cross generational linkages, and be kept in place for a sufficient length of time to ease developmental transitions" (Boderick & Blewitt, 2015, p. 35). This equates with compassionate management practices that tackle stigma and discrimination to secure healthful working places and spaces (Jansson & Gunnarsson, 2018).

While many people experience elevated levels of mental health as a result of their work, a substantial body of research has demonstrated the links between work related risk factors / job stressors / psychosocial hazards and employees' mental health (LaMontagne et al., 2014). Identifying the factors that may protect employees from experiencing distress in their workplace, developing and enacting sustainable mental health workplace policies and processes, promoting an organised approach to healthy workplace cultures, reducing the impact of work related risk factors, optimising prevention and management of common mental health challenges, integrating aspects of health promotion interventions into daily work practices are possible actions facilitating mental health promotion, prevention and early intervention (LaMontagne et al., 2014; Page et al., 2014; Westerhof & Keyes, 2010).

The emotional strain involved in working in a pressured workplace means employees can often experience burnout as a result of setting aside their own self-care needs when helping others. While burnout is not classified as mental ill-health, a direct consequence of burn-out is increased mental illness, as it impacts psychological health and workplace performance. Wellbeing at work can be cultivated through managers and leaders intentionally focusing on employees strengths, "seeking to recognise and appreciate the character strengths of their employees and then facilitating opportunities for strengths-use" (Wilkie, 2017, p. 13). Studies have found people who employ their strengths in the workplace report good mental health, higher levels of positivity, engagement and productivity (Corporate Leadership Council, 2004; McQuaid, 2017; Seligman, Steen, Park, & Peterson, 2005; Wood, Linley, Maltby, Kashdan, & Hurling, 2011).

Leaders and managers in higher education could employ the Kelloway and Day (2005) six-phase framework to promote psychologically healthy workplaces: institute supportive, autonomous and respectful workplaces; involve employee in mental wellness practices and processes; promote physical and psychologically 'safe' environments; promote interpersonal connections with co-workers and managers; safeguard fair work content and characteristics; and endorse flexible workplaces in a desire for work-life balance. Enacting this framework demands intentional leadership with a commitment to addressing and changing unconscious and conscious prejudicial attitudes, all the while understanding Duffy and Sedlacek's (2007) individuals' intrinsic motivation to work (e.g., work ethic, self-identity, self-fulfilment, self-worth, socialisation, public roles). This entails diversity awareness and action, addressing stigma and discrimination with fairness and justice, change management systems consistent with empowerment and innovation, and

collaborating with staff, health care professionals and mental health care systems.

Supportive environments can facilitate the provision of compassion, although individuals need to take responsibility and be accountable for their behaviour choices (Glasser, 1999). Compassion is the practice of recognising and understandings others' suffering as well as one's own. Advocating for relationship-based connectedness, Barson's (2018) plenary address at the Australasian Mental Health and Higher Education Conference (AMHHEC) titled *Compassion Cultivation in Higher Education – A Missing Ingredient for Mental Health*, acknowledged compassion, a construct of Buddhist thinking (dharma), as an enabler of mental health and wellness. Barson (2018) described compassion as a powerful predictor of psychological wellbeing, a definite enabler in dealing with "work demands and pressures that are not matched to their knowledge and abilities and which challenge their abilities to cope" (World Health Organization (WHO), 2018, para 3). Connecting with one's feelings and caring for own welfare is foundation to cultivating compassion for self and others (Barson, 2018; Germer & Neff, 2013). At the organizational level compassion practices might include setting realistic goals with regard to workload, actively encouraging the use of breaks, "discounted membership for health and fitness facilities and flexible work schedules … complementary mindfulness training and massage therapy" (Dimoff & Kelloway, 2018b, p. 1).

Resonating with the writings of Germer and Neff (2013), Barson (2018) advised the core of cultivating compassion "is the ability to connect to one's own feelings and to care for one's own welfare … caring for others requires caring for oneself" (Germer & Neff, 2013, p. 48). There is an art and science to self-care, one that blends intentionality with intuitiveness. Individuals act intuitively when they do things they think they should do, learning and doing whatever they can for their own wellness. Intentionality is influenced by self-efficacy - one's successful application of learned behaviours influences motivation to repeat these behaviours in the future (Bandura, Barbaranelli, Caprara, & Pastorelli, 1996). The art and science of self-care is practiced by intentionally adopting certain practices, and intuitively blending them together. It is neither intentional versus intuitive, but a combination of both.

Self-care refers to the active process of refreshing, recharging, maintaining, promoting, recovering, and improving one's well-being throughout life (Coaston, 2017; Newell & Nelson-Gardell, 2014). It encompasses practices intentionally undertaken that are aimed at personal development, as well as professional development. These practices, often recorded in self-care plans, might include

accessing employment assistance programs, debriefing with colleagues, time management, practicing self-compassion, leisure-time physical activities, and humour (Coaston, 2017; Vincett, 2018). Introspective self-care typically involves counselling, and other types of self-reflection, such as reflective journaling, creative writing, meditation, yoga, and mindfulness-based stress reduction (Newman, 2016; Slonim, Kienhuis, Di Benedetto, & Reece, 2015; Yuen, 2011), as well as technology based interventions (Conley, Durlak, Shapiro, Kirsch, & Zahniser, 2016; Davies, Morriss, & Glazebrook, 2014; Hickie, 2018; Orman, 2017). The Tree of Competitive Practices is a valuable resource, illustrating self-care contemplative practices for deliberation:

http://www.contemplativemind.org/practices/tree.

Central to overall wellness is mental and physical health. This includes regular physical exercise, sleep, and health checks, and eating a variety of foods that include fruits, vegetables, low-fat and fat-free dairy products, lean meats, fish, chicken, bread, and pasta. Balancing food with physical activity is important. Roberts' (2018) AMHHEC keynote *Equally Well Quality of Life-Equality in Life* discussed the Equally Well project designed to improve the physical health of people living with mental illness in Australia. This national person-centred practice approach promotes collective action, collaborative sharing of resourcing, reshaping promotion, prevention and early intervention, equity of access to service focused integrated quality care, seamless care and progress measurement.

Implications and ways forward – what are the potential implications and ways forward to promote uptake of enablers of mental health and wellness for individuals and communities?

The authors of this paper have explored agreed definitions of mental health and wellness as well as identified existing pressures and contextual factors influencing the overall mental health of those working within universities. Also identified herein are details of system level responses within universities aimed at supporting the mental health and wellness of staff and students. Self-care and the links between mental health and physical health as potential individual enablers of wellness are also noted.

These system interventions and individual enablers share the common goal of developing and promoting MHL and awareness at an individual, community and institutional level (Ashfield,

Macdonald, Francis, & Smith, 2017). Wei, McGrath, Hayden, and Kutcher (2015, p. 2) suggest MHL and awareness encompasses recognition of mental illness symptoms, knowledge of mental ill-health and positive mental health, and attitudes about mental health, stigma and efficacy in help seeking. This incorporates four dimensions:

1. understanding how to obtain and maintain good mental health
2. understanding mental disorders and their treatments
3. decreasing stigma against mental illnesses (at an individual, community and institutional level)
4. enhancing help-seeking efficacy.

According to Rafal, Gatto, and DeBate (2018), low levels of MHL, especially within particular groups, such as male university students, can result in decreased mental health and wellness. Rafal et al. (2018) contend universities not only need situational systematic approaches, but argue, targeted interventions need to be explored. Emphasising prevention, promotion and early intervention such approaches could focus on the four domains of MHL for particular groups, for example, addressing stigma related to help seeking, which can impact the uptake of mental health services for particular groups (Rafal et al., 2018). Holt and Powell (2017) support this argument and advocate that universities need to research the health and wellness needs of their own populations in order to tailor *hope-inspiring practices* (Spandler & Stickley, 2011) and specific institutional programs and interventions for specific groups and at specific times. Such authentic actions are designed to enhance meaning making and need to be "nurtured in contexts, through relationships, cultures and healing environments" (Spandler & Stickley, 2011, p. 555).

A key element of MHL and awareness is help seeking. This process is complicated and as recounted in the literature, there is a significant gap in reported help seeking behaviours and services received (Cauce et al., 2002; Cheng, Wang, McDermott, Kridel, & Rislin, 2018; Martin, 2010; Sontag-Padilla et al., 2018). Cauce et al. (2002, p. 50) propose a mental health help seeking model, inclusive of three steps: "problem recognition, the decision to seek help, and service selection". However, Cauce et al. (2002) contend this process is not simple or linear. Cheng et al. (2018) argue, despite high numbers of people within universities who meet diagnostic criteria for mental health issues, the data of those that actually seek help for such issues is disturbingly low. For Cauce et al. (2002) help seeking cannot begin until a problem is first observed and recognised and as Cheng et al. (2018) identify, MHL is required in order to understand the nature of the

problem as a mental health issue as opposed to signs of daily stress. Once a problem is recognised (either by an individual or other), help seeking cannot be guaranteed and instead can be influenced by culture, family, gender, context, social networks and so on (Cauce et al., 2002). Finally, when a decision is made to seek help, people are often unclear about which services to choose or what help is available (Cauce et al., 2002). Clearly, the challenge for enhancing MHL of those within universities is identifying the most appropriate of both.

Within an institutional approach, targeted interventions could support MHL and wellness at both the community and individual level. There is some evidence (e.g., Conley, Durlak, & Kirsch, 2015; Lipson, Speer, Brunwasser, Hahn, & Eisenberg, 2014; Woloshyn & Savage, 2018) that individuals can improve their MHL by engaging with evidence based prevention strategies, and connecting with persons experiencing mental ill-health or who are recovering from mental illness. For Sontag-Padilla et al. (2018), one-contact or short-term (traditional) courses aimed at advancing knowledge, reducing stigma and enhancing attitudes about mental health and mental health problems, such as Mental Health First Aid, need to be enacted alongside long-term, campus-based, large-scale programs in order to make a meaningful difference to individuals' knowledge, attitudes and behaviours. Whilst Songtag-Padilla et al. (2018) argue such an approach can enhance individual knowledge as well as develop peer-support programs, knowledge alone does not guarantee engagement. A sense of self-efficacy, self- confidence and self-acceptance is required for persons to recover from adversity, become acquainted with MHL and wellness resources and to unreservedly access and engage with these resources.

Conclusion

Exploring potential enablers and possible implications for promoting mental wellbeing of those working in universities is vital due to the alarming mental ill-health statistics reported in the literature. Leaders and managers in higher education who intentionally promote positive mental health are well positioned to play a buffering role, supporting teaching academics as they cultivate positive mental health and wellness practices for thriving in their workplace. This positioning is well supported by literature and policies calling on the higher-education-decision-makers to lead the implementation of systemic approaches to support the mental health and wellness of those working and learning within this space. Such systemic approaches, however, need to involve context-specific programs, whereby, individuals and communities within higher education

institutions work collaboratively on wellness promotion, prevention and early intervention. These approaches need to emphasise knowledge and skills in MHL and awareness to support individuals to understand and appreciate their wellness needs in conjunction with seeking help for mental ill-health without stigma anxiety. The MHL programs need to be inclusive of long-term, on-the-ground compassionate approaches, which foster and sustain individual and community mental health and wellness. Raising interesting areas for future studies, the authors have identified ways forward for promoting and improving mental health outcomes for those working in universities, including: exploring existing research metrics that can be employed to measure the MHL of individuals and groups within a university in order to target specific wellness practices, mental health supports and training needs; investigating ways potential enablers can be enacted to reduce the gap between those identified as needing support, services approached and services received; and probing existing performativity scales and workloads to ascertain potential areas contributing to positive mental health and mental ill-health of staff.

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