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Enablers and barriers to mental health initiatives in construction SMEs

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Background Mental ill-health is prevalent in the construction industry, and workers in small- to medium-sized enterprises (SMEs) are at high risk. Knowledge about the implementation of mental health initiatives in construction SMEs is limited.

Aims To explore enablers and barriers to implementing mental health initiatives within UK SME construction firms from the perspective of the business owners, directors and managers with responsibilities for workplace mental health.

Methods Qualitative study involving semi-structured interviews conducted with company owners/managers with responsibilities for workforce mental health. Participants were sampled from construction SMEs in the UK.

Results Eleven construction professionals were interviewed (10 men, 1 woman; aged 34–55 years, M = 40.6) representing UK SME construction firms that were micro (<10 employees, n = 8), small (<50 employees, n = 1) and medium (<250 employees, n = 2) sized organizations. Reflexive thematic analysis generated four themes: (i) traditional views and macho culture, identified as barriers to implementation; (ii) mental health awareness, knowledge and education; (iii) valuing good mental health and (iv) a reactive or proactive approach to mental health, which all served as both enablers and barriers depending on perspective and context.

Conclusions This study sheds light on an under-researched but high-risk category of workers experiencing poor mental health. We provide recommendations for policy and practice with a 'call to action' for SME owners, industry and policymakers to embark on workplace mental health implementation projects in SME settings.

Introduction

In Britain, 2.2 million working days are lost to ill-health accounting for 1.7 million (75%) of working days lost [1], and a burden to the UK economy of at least £117.9 billion per year [2]. Construction is a major sector in the UK economy (6.6% of all jobs) [3].

Mental ill-health is described as a 'silent crisis' within the construction industry [4]. Work-related stress has been reported by 97% of construction professionals surveyed by the Chartered Institute of Building [4]. Suicide risk is 3.7 times higher in construction than the national average for the UK [5]. The predominance of a largely young, male workforce, with relatively low educational attainment and poor job security are known risk factors for mental illness, self-harm and suicide [6]. Health-seeking behaviour is limited in this industry by stigma and low levels of support [7]. Small- to medium-sized enterprises (SMEs: ≤250 employees) account for 99.9% of the total business population in the UK [8] with the largest number of SMEs (914 175 or 17%) operating in construction [8,9].

SMEs are less likely than larger companies to implement preventive measures and they report more barriers and challenges to implementing health promotion [10,11], albeit lack of time and funding are commonly reported barriers, irrespective of organization size [11]. Mental ill-health is a particular concern in SMEs [12,13]. Smaller construction companies and the self-employed are particularly at risk as they are less likely to have established workplace mental health structures and policies in place [14]. They may lack the resources to implement mental health support, and/or due to their position in the supply chain they may not benefit from the occupational health provisions offered by large corporations [6]. Health prevention activities are often viewed as a 'luxury' in SMEs rather than a core focus of organizational activity [11]. However, the determinants of implementation of mental health initiatives in SMEs remain inadequately explored . Although SMEs predominate in construction, these settings are considered a 'neglected sector' and are under-researched [15,16], with micro-enterprises (<10 employees) viewed as 'particularly deficient with regard to their knowledge on, access to, and implementation of supports around mental health' [17].

In a systematic review [18], the most cited factors influencing the implementation of preventive initiatives in larger construction workplaces were cost, time, facilities and resources, transient workforce, delivery method, influence from managers, long working hours, masculine culture, production pressure and interest. This review did not include SMEs, and the authors called for more research on enablers and barriers to

Key learning points

What is already known about this subject:

- Mental ill-health is prevalent in the construction industry with a high economic and societal burden. Although risk factors for mental ill-health have been established, many organizations have no policies or practices in place relating to mental health at work.
- Small- to medium-sized enterprises are at particular risk for mental ill-health but are an under-researched setting, and the barriers and enablers of implementing mental health initiatives in construction small- to medium-sized enterprises need to be explored.

What this study adds:

- This study provides insights from the perspective of owners and managers into factors which help or hinder construction small- to medium-sized enterprises in implementing mental health initiatives.
- Mental health stigma and macho culture were identified as barriers to implementation.
- Mental health awareness, knowledge and education, valuing good mental health, and a reactive or proactive approach to mental health served as enablers or barriers depending on perspective and context.

What impact this may have on practice or policy:

- Efforts are required to raise awareness of mental health, increase mental health literacy and reduce mental health stigma in small- to medium-sized enterprises.
- Case studies of best practice may help to put mental health on small- to medium-sized enterprise employers' agendas and encourage proactive approaches to prevention of mental ill-health.
- Initiatives are needed to support small- to medium-sized enterprises with development of mental health policy and practices, with guidance relating to employer roles, responsibilities and mechanisms for identifying, managing and supporting employees with mental health concerns.

implementing health promotion initiatives in construction, and specifically SMEs [18].

Exacerbated by the COVID-19 pandemic, there is a growing 'mental health problem' in the construction industry [19]. There is an urgent need to explore the barriers and enablers to implementing mental health initiatives in construction SMEs. Therefore, we aimed to qualitatively explore from the perspective of owners and senior management, the factors which enable or hinder the implementation of mental health initiatives within SME construction firms in the UK.

Methods

A qualitative interview study was conducted. Reporting is guided by the COREQ-32 consolidated criteria for reporting qualitative research (COREQ-32) [20]. Ethical approval for the study was granted in June 2022 by the institutional Research Ethics Committee (Ref: DoPAP 2945). A convenience sampling approach was used to recruit key informants who were (i) owners or managers within UK SME construction firms; (ii) working in firms that had been established for 2 or more years; and (iii) from micro-, small- or medium-sized enterprises that employed a minimum of five people. Study promotional materials were sent to selected organizations via professional business networks and social media postings (LinkedIn) between July and August 2022. Interested participants contacted the researcher by e-mail, were telephoned to explain the study purpose and establish rapport and provided with a study information sheet. Those wishing to take part provided written informed consent. No incentives were given for participation. Interview discussions were informed by an interview topic guide (Supplementary File S1, available as Supplementary data at *Occupational Medicine* Online), developed by the research team and pilot tested. Interviews were conducted by one researcher (H.Bu.) and for maximum flexibility were offered by video call, telephone or face-to-face at participant preference. Field notes were taken during interviews. No repeat interviews were undertaken. Interviews were digitally recorded with consent, transcribed verbatim using a professional automated transcription service and anonymized. Data were collected until the researcher deemed the data set to provide sufficient 'information power' [21]. Due to time constraints, transcripts and study findings were not returned to participants for comment.

Data were analysed using NVivo v.11 software package (QSR International, Australia). Data were explored and analysed thematically using Braun and Clarke's [22] six-stage process to identify patterns (themes) to address the research aim. Reflexive thematic analysis of the data was chosen since it is a theoretically flexible and interpretative approach that is appropriate for an under-researched topic that is exploratory in nature. This approach encourages researcher reflexivity in making sense of the data; thus, inter-coding reliability was not assessed. The researcher (H.Bu.) read interview transcripts in detail to familiarize with the data and note initial ideas. Initial codes were then generated, noting interesting features both at the semantic and latent level, and similar codes were clustered together and collated manually into potential themes that were derived from the data. Two researchers (H.Bu. and N.C.) reviewed the initial themes and checked back both at the code level and with the full data set to refine and ensure a good fit. Themes were defined and named, and quotes were selected which best represented the theme. This rigorous and systematic approach, although staged, was iterative and recursive. The interviewer (H.Bu.) was female, a prior small business owner and mental health advocate, who was studying for a higher degree in occupational psychology and had undertaken training in qualitative methods and interview skills. Her background

provided insights into data analysis and interpretation, and reflexivity was established by (i) taking field notes during the interviews, (ii) writing memos as soon as possible after each interview and (iii) continually reviewing and revising a subjectivity statement.

Results

Of 16 construction professionals expressing interest, 11 provided informed consent and were interviewed (10 male, 1 female; aged 34–55 years, M = 40.6). Participants represented UK SME construction firms that had been established for 2–88 years (M = 15.8). Interviews were conducted by telephone, in working hours (between 08:00 and 18:00) and participants were at their place of work. Only the researcher and participant were present for the interviews, which lasted 37 min on average (range: 19–62 min). Sample characteristics are shown in Table 1.

Reflexive thematic analysis of the data generated 4 themes and 10 subthemes (Figure 1): (1) Traditional views and macho culture, (2) Awareness, knowledge and education, (3) The value of good mental health and (4) A reactive or proactive approach to mental health.

Theme 1 describes the views and experiences of interviewees regarding negative attitudes and behaviours towards mental health within the construction workforce and ingrained stigma associated with mental health. Discourse relating to mental health was generally avoided in the construction workplace. Older workers were seen to be particularly unreceptive to open conversations about mental health, compared to their younger counterparts. Negative attitudes and mental health stigma were ingrained in workforce culture from the top down, leading employees to avoid disclosing mental health concerns for fear of negative reactions from managers:

> Some of the older generation just think, "you know, we didn't have it in our day, you know, pull your pants up and get on with it". (P7)

Participants discussed the *challenges* of initiating change within a predominantly male workforce in which 'bravado' and 'macho culture' were dominant. This was described as a 'man-up culture' (P3), which prevented workers talking about mental health even to colleagues: 'You don't like to admit it as a bloke' (P1) or accessing support on-site (e.g. mental health ambassadors) which was seen as '…a sign of weakness' (P6). The perceived lack of empathy and support from managers and colleagues engendered an expectation of self-reliance and 'toughness', that played a key role in workers being resistant to help-seeking, isolating individuals from accessing support mechanisms.

This negative workplace culture was seen to be unsurmountable by some, that would require a change of leadership (e.g. younger managers moving into leadership roles) for attitudinal shift. One interviewee shared that efforts to tackle this culture were starting to take effect, albeit slowly:

> …men reaching out now, it's not where it needs to be, but… the stigma is being diluted. (P10)

Theme 2 describes a shared feeling expressed by interviewees of an insufficient awareness, firstly 'about mental health in

Table 1. Participant characteristics

ID	Gender[a]	Age	Job role	Company size[b]	Established (N° years)	Region
P01	M	35	Owner	Micro	7	West Midlands
P02	W	42	Project Manager	Micro	5	East Midlands
P03	M	42	Owner	Small	15	Southeast
P04	M	34	Owner	Micro	2	East Midlands
P05	M	37	Owner	Small	7	East Midlands
P06	M	44	General Manager	Medium	13	East Midlands
P07	M	46	Owner	Small	13	East Midlands
P08	M	55	Project Manager	Medium	88	East of England
P09	M	38	Owner	Micro	7	East Midlands
P10	M	38	Owner	Micro	7	East Midlands
P11	M	34	Owner	Micro	10	East of England

[a]M: man/F: woman.
[b]Micro (<10 employees); small (<50 employees); medium (<250 employees).

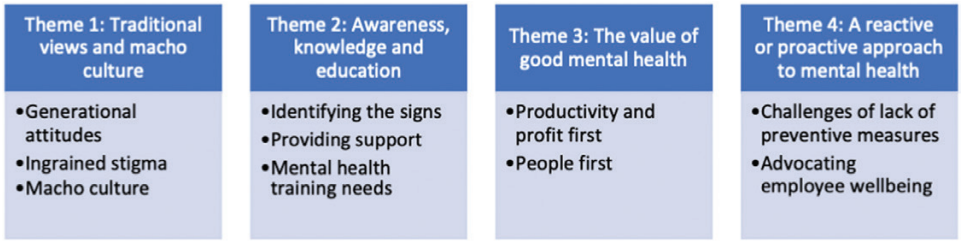

Figure 1. Themes and subthemes.

general' (P11), and secondly, about how to approach, and have conversations with workers about their mental health and where to signpost them for support. Some interviewees felt conflicted as they wanted to help but did not feel they had the knowledge or skills to do so:

> I don't even know who I would refer to or speak to regarding how I'd set up like a mental health policy or anything like that…I wouldn't really know where to start. (P5)

This stemmed from workforce training primarily being focused on health and safety, or skill mix in the workforce, and lacking a well-being component. Interviewees referred to a lack of understanding about their roles and responsibilities as an employer or manager related to mental health at work: 'there might be a government policy in place, I genuinely don't know' (P4). This knowledge deficit left them feeling vulnerable in discriminating between workers with genuine mental health concerns, and those who might 'abuse the system'.

> Because it's a hidden illness and it's not something, it's not something you can see …if I say that our mental health policy is 'X' then, are they gonna take us for a ride? (P4)

A prevailing concern that mental health policies may be used inappropriately by some workers, and the language being used by workers and managers when discussing mental health, was viewed to exacerbate mental health stigma in the workplace. While there was an evident need for employer training in responsibilities and processes (i.e. the prevention and management of mental ill-health), some interviewees alluded to a need for additional training for managers, focused on changing attitudes to mental health and addressing mental health stigma.

Theme 3 describes how the interviewees perceived the issue of addressing employee mental health as either a cost to the business or an investment in the business and their employees. Particularly for micro-organizations, the main barrier to implementing mental health initiatives was the financial cost, exacerbated by precarious labour market positions generating financial instability for SMEs coupled with the enduring impacts of the COVID-19 pandemic. Some interviewees referred to a 'productivity-first' or 'profit-first' mentality within the construction industry:

> …to spend money on something that you can't see the result of, in the commercial sense, it just, just doesn't seem like a good idea. (P3)

In contrast, other interviewees perceived addressing mental health to be an investment for their company; this perspective reflected a 'people-first' mentality. To these managers, employees were an important asset and looking after well-being was seen to incur long-term benefits such as reduced sickness absence, better staff retention and increased productivity.

> …not everything is money driven, people want to be valued, people want to be respected, people wanna feel appreciated …effectively that all comes back down to the bottom line of the business. (P10)

Those interviewees focused on 'investment' and 'people first' tended to be younger, demonstrate greater awareness of the extent and impact of mental ill-health in the construction industry or had personal experience (e.g. through observing illness or death of a colleague related to mental ill-health). In contrast, interviewees using 'profit-first' language tended to be older, with less awareness and knowledge about mental ill-health and its impacts.

Theme 4 describes how the views and perspectives of the interviewees towards mental health within the construction workplace have translated into actionable approaches or initiatives which have either been proactive or reactive in their nature. Interviewees mostly referred to reactive approaches; this put the onus on the employee to disclose their mental health issues which was hindered by negative workplace culture, stigma and poor management practices. One interviewee reflected on a co-worker having taken their own life, and the circumstances of the organization in which this occurred, notably, a lack of policies or structured support for mental health at the time:

> one of the reasons why nothing was there, was because it was never…a fire that we had to deal with… for us it was out of nowhere, we didn't realise that he was suicidal. (P3)

In contrast, some interviewees discussed more proactive approaches within their organizations. They referred to the provision of supportive tools and resources for managing mental well-being, the promotion of 'down-time' and work–life balance, and advocating social interaction as well as regular contact time between managers and employees:

> … at least over a monthly basis I would have a one to one with all of them…I spend most of that time asking about them as opposed to asking about the work. (P6)

Proactive approaches tended to be taken by interviewees who demonstrated a greater awareness of the causes of mental ill-health and recognized the complex relationship between the unique environment of the construction industry, relationships and support at work, physical and mental health, and aspects of non-work life.

Discussion

Our study revealed a negative impact of a masculine culture within construction SMEs, mental health-related stigma and negative attitudes to mental health, held particularly by the older generation of workers. SMEs largely adopted a reactive rather than proactive approach to mental ill-health, and policies or practices in place relating to mental health at work were lacking. Participants identified a need for training, education and support relating to attitudes towards mental health and reducing stigma, mental health prevention (i.e. identifying the signs and symptoms of mental ill-health, raising awareness of mental health in the industry) and management of employees who raise mental health concerns (i.e. understanding roles and responsibilities, policies, guidelines, support and signposting). A key enabler of implementing mental health initiatives was attributing value to employee

Table 2. Mapping of themes to study implications aligned with national recommendations for mental health at work

Themes	Implications (adapted from NICE, 2022)
Theme 1: Traditional views and macho culture	• Foster a positive, compassionate and inclusive workplace environment and culture. • Increase psychological safety, i.e. a person's desire and need to feel comfortable and safe in the workplace to express themselves and communicate openly. • Encourage and facilitate peer support, e.g. using mental health champions, peer mentoring and 'buddying'. • Encourage employees to recognize and take action to prevent discrimination in the workplace, e.g. through staff networks. • Raise awareness of mental health impacts outside the workplace. • Advocate communication and engagement between employees.
Theme 2: Awareness, knowledge and education	• Promote owners' and managers' well-being, encourage peer-to-peer support. • Regular training and support for managers, e.g. in line management and leadership style, communication skills, management and monitoring of mental well-being, identification of warning signs, mental health promotion and resources, stigma awareness/mental health literacy and manager-proposed topics. • Minimize training costs by using free resources. • Empower managers to make work adjustments, e.g. to workload and work intensity. • Evaluate impacts of manager training on employee outcomes.
Theme 3: The value of good mental health	• Present business case for focusing on mental health at work, which details financial return-on-investment, and advocates 'people-first' employment strategies. • Use case studies of successful mental health initiatives in SMEs to provide examples of best practice to be modelled. • Consider incorporating mental health into health and safety training (to generate comparable perception of 'value'). • Encourage owners/managers to take a leadership role in championing mental well-being. • Create opportunities to foster good relationships with (and between) employees, e.g. socializing, meetings. • Encourage managers and employees to have open conversations about mental well-being. • Encourage employee access to physical and mental health interventions, minimize barriers to access, e.g. financial, job-related, protected characteristics.
Theme 4: A reactive or pro-active approach to mental health	• Take a preventive approach to mental well-being at work, e.g. using training in mental health and communication skills to foster positive mental well-being in workforce, involving employees in identifying and minimizing stressors. • Adopt a tiered approach to mental health at work with organizational-level initiatives (bottom), individual-level initiatives (middle), targeted initiatives (top). • Develop equitable and inclusive policies, processes and ways of working. • Encourage supply chain organizations to promote mental well-being among their employees, e.g. using contracting and ethical procurement arrangements. • Embed well-being into the overall business strategy of all organizational policies and practices. • Sign up to the 'Mental Health at Work Commitment'[a] (a set of actions that any organization can follow to improve and support the mental health of their people). • Use workplace accreditations or charters, e.g. Workplace Wellbeing Charter, Mindful Employer and Mind's Workplace Wellbeing Index. • Conduct stress risk assessment for each role and discuss with employees. • Identify and reduce work stressors by referring to guidance and best practice on job quality, work design and organization, e.g. HSE Management Standards. • Ensure systems are in place to provide support for employees for whom external factors are influencing their mental well-being. • Provide employees with free access to employee assistance programmes and occupational health services (with time and private space to attend). • Tailor interventions to organization size; engage employees and other stakeholders in determining needs. • Have a plan for responding to unexpected traumatic events affecting employees, e.g. pandemic, death of colleague, terrorist attack. • Seek advice and support from local authorities; local enterprise partnerships; voluntary, charity and social enterprises; trade unions and other bodies. • Monitor and evaluate support provided at least annually using a relevant tool and validated measures of well-being.

[a]https://www.mentalhealthatwork.org.uk/commitment/.

mental health, either with a 'people-first' mentality (i.e. morale and job satisfaction) or as a 'financial investment' for bottom-line benefit (i.e. productivity or profit). The financial cost of accessing mental health training or implementing mental health initiatives was a key barrier for SMEs, which is not unexpected given the precarity of the labour market for SMEs, particularly during a period of economic uncertainty and global pandemic, and the broader context of construction—with highly competitive markets, low-profit margins and tight timeframes [17]. Several of the factors identified in this study have been observed in other sectors with high masculinity culture (e.g. mental health stigma and low help-seeking in law enforcement officers [23]). While many of the barriers identified in our study are relevant in construction organizations of all sizes (e.g. macho culture, stigma), the lack of access to resources (i.e. for training, education and support) and a lack of understanding as to where to seek free or low-cost help for prevention or management of mental ill-health in employees was highlighted as a specific problem for SME owners and managers.

Our findings are limited to the views of study participants who were predominantly White British men working within small and micro-businesses. However, 95% of all UK SMEs are micro-businesses and workplace mental health research focused on micro-organizations is sparse [14]. Our participants had diverse occupational experiences from a range of subsectors within the industry and work both on-site and off-site, including specialist construction activities. Recruitment took place during the COVID-19 pandemic impacting on accessibility of business owners and managers; convenience sampling maximized participation although may have increased risk of sampling bias.

Our research, combined with evidence in the literature, provides the impetus for employers, policymakers, charities, and professional bodies to act on this knowledge to facilitate, support and/or implement workplace mental health policy and initiatives in UK SMEs. We confirmed prior suggestions that SME employers lack policies and practices relating to mental health promotion [14], can lack awareness about mental health and primarily engage in 'reactive' approaches to dealing with employees already experiencing mental health issues [10].

Construction SMEs are described as 'hard to reach' [6], with low levels of mental health literacy and hegemonic masculinity identified in construction workers, inhibiting help-offering and help-seeking behaviour in mental health [6]. In the UK, the National Institute for Health and Care Excellence (NICE) guidelines for mental well-being at work [24] were informed by an evidence review exploring barriers and facilitators to implementation of mental health interventions. Of nine studies, only two considered the views of participants from construction settings [25,26]. Hanna and colleagues [26] found that the construction sector was viewed to be 'anti-health promoting' but this study did not include the views of owners or managers from smaller organizations. Carmichael and colleagues [25] identified a negative impact of a macho culture within the industry, a lack of willingness to discuss mental health and financial barriers, although the organization size of the seven construction participants included was not reported.

Implications for construction employers are shown in Table 2, in which themes identified in our data are mapped to recommendations in the NICE guidelines for mental well-being at work [24].

Our study addresses this evidence gap and contributes to the broader research landscape on mental health in the construction industry which is described as 'embryonic' [27]. Given low levels of participation from owner/managers within the building and construction sector (compared to other sectors) in workplace mental well-being interventions [28], our study provides timely and valuable insights into the barriers and enablers of implementing workplace mental health initiatives in construction SMEs. SMEs owners and managers need support in developing a proactive approach to mental health at work in line with current national guidance [24] . Further research is needed to explore the views of other stakeholders (e.g. employees, policymakers) and determine the types of intervention that are more, or less effective in SMEs.

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Competing Interests

HB has received funding from Gilead Sciences, Inc., Midlands Engine and the Economic and Social Research Council, for unrelated work. No other competing interests have been declared.

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