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Editorial

Workplace mental health screening for trauma-exposed workforces

Mental health screening protocols in organizations that routinely expose workers to intense psychosocial hazards, such as the emergency services, military and healthcare, attract considerable interest. Many trauma-exposed organizations [1] currently use screening to protect their workers' mental health, but surprisingly there is scant research into how effective these programmes are [2]. It thus remains unclear whether screening should be an organizational psychological health risk mitigation measure, and if so, how it should be organized?

Screening aims to identify people within an apparently healthy population at risk of a defined health problem, who might benefit from interventions to reduce the incidence and associated morbidity or mortality [3]. Within an organizational context, psychological health screening might guide decisions regarding suitability of workers before commencing specific higher-exposure roles or identify treatment needs post-trauma or for those working in persistent trauma-prone roles.

Two factors, however, can disrupt any debate about the utility of mental health screening. The first factor is that there are multiple interpretations as to what mental health screening is, which can generate confusing conversations about dissimilar processes. For example, some might consider supervisors systematically checking in with staff post-incident to detect adjustment concerns as a form of screening, whereas others consider screening only refers to structured, online or in-person, healthcare-delivered, systematic processes similar to diagnostic detection. We argue that screening discussions require clarity about the practices being referred to; otherwise, interpretation of published evidence is challenging.

The second factor is that organizations need to consider how various components of a screening programme fit together. Firstly, there is a need for tools capable of correctly identifying current or impending mental ill-health. Secondly, there is a necessity for acceptable interventions to effectively reduce the likelihood of workers developing mental health disorders or facilitate recovery for those who already have. Thirdly, there is a requirement for an organizational culture that fosters trust, whilst minimizing organizational disincentives for staff engaging honestly, and in a timely manner, with the screening process. Finally, people identified as higher risk need to fully engage with potentially beneficial interventions. Failure of any component renders the overall screening process ineffective. For instance, a stigmatizing workplace culture, with potential ostracization, or job loss, after screening positive, would deter workers from engaging honestly with screening or seeking care after participation.

So, what is the evidence for the effectiveness of mental health screening within trauma-exposed workforces? A recent meta-analysis of randomized controlled trials (RCTs) of workplace mental health screening using validated tools, such as the Patient Health Questionnaire (PHQ)-9 for depression or the post traumatic stress checklist for DSM-5 (PCL-5) for post-traumatic stress symptoms, did not result in improved worker mental health [2]. Similar findings have been found in studies of higher exposed workforces. For instance, a UK RCT of post-deployment online screening of military personnel found no mental health benefits; furthermore, those screening positive frequently did not access the healthcare they were advised to seek [4]. US research examining the impact of questionnaire, and healthcare professional-based, screening of military personnel at two time points post-deployment found no clear positive relationship between screening response, referral, uptake of care and mental health outcomes, even where care was accessed [5]. However, using the broader conceptualization of screening, an RCT found much reduced sickness absence as a result of systematically training fire station managers to routinely speak with firefighters about their mental health [6]. This is consistent with recent World Health Organization guidance, which reinforces the role of managers in protecting workers' mental health [7].

So, what considerations should organizational leaders within trauma-prone workplaces make about the use of mental health screening to support their workforces? Firstly, despite its widespread use, current evidence to support the effectiveness of formal mandated mental health screening in organizational settings is lacking [2,5]. Secondly, if used, screening should be part of a systemic approach to supporting workforce mental health that includes fostering an organizational culture that minimizes disincentives for staff to engage honestly. Thirdly, screening could only work if it leads to timely access to evidence-based interventions. Fourthly, utilizing an extended definition of mental health screening, there is preliminary evidence that supervisors capable of genuinely and skilfully inquiring about staff well-being may reduce mental ill-health and sick-leave absences [6,7]. Fifthly, albeit more speculatively due to a dearth of research, facilitating naturally occurring formal, and informal, social networks has the potential to protect workers' mental health. For example, training workplace peers [8] to better identify, and support, those at higher risk of

mental ill-health. Sixthly, evidence shows both that treatment for workers at risk of developing mental health disorders can be effective [9], and that workers often prefer to self-manage mental health problems [10]. Therefore, there may be merit in trialling providing workers a voluntary, readily accessible self-screening process, linked to evidence-based self-help tools with the option to access professional support if they wish.

Organizations with trauma-exposed workforces should also be aware that ineffective screening has the potential to cause harm. For example, a positive pre-role screen may inappropriately label someone as high-risk, preventing them from being allowed to take up a desired role. Additionally, limited financial resources spent on workplace screening are not available for improving workforce well-being in other ways. Overall, whilst cautious use of some screening approaches could be helpful as part of a broader systematic approach to workplace mental health, the current state of evidence does not support its mandatory use by trauma-exposed organizations.

Competing interests

D.F. declares no competing interests. N.G. runs a psychological health consultancy called March on Stress Limited, which provides psychological support to several trauma-prone organizations. The opinions and assertions expressed in this comment are those of the authors and do not reflect the official policy or position of the authors' governments or institutions.

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