Work-based education about depression: ethical dilemmas revisited and a new workplace literacy emerges

Lisa Davies, The University of South Australia, Australia

Paper presented at the 40th Annual SCUTREA Conference, 6-8 July 2010, University of Warwick, Coventry

Introduction
In an examination of a re-emergence of some ethical dilemmas which adult educators may experience, and emerging policies about the urgent need for work-based education about depression, this paper reflects the conference themes of historical and current research in pedagogical and policy practices, and the role of adult educators.

A large, qualitative investigation undertaken in some Australian organisations revealed managers’ beliefs about the value of work-based education and depression. Further to this, in this paper I examine the literature related to Australian activities which parallel those undertaken in Britain, Canada, New Zealand and the United States of America (World Health Organisation, 2001) which have been proposed and utilised in workplaces to increase awareness of and knowledge about depression, or what is now often referred to as the acquisition of ‘mental health literacy’.

Is adult education for social justice or for an economic imperative?
There is a tension inherent in the Australian government responses to the information about the increase in the identification, if not prevalence of depression. This is exemplified by the distinctions between the motivational factors which underlie taking social action. Some drivers are based upon an economic imperative in which early detection and assistance is perceived as essential to maintain or increase employee productivity. By contrast others are centred in a social justice perspective - commonly associated with respect to the social milieu, multi layered literacy practices and a valuing of the ‘other’ - in which education is intended to reduce discriminatory or stigmatising behaviours. This is a dichotomy which is familiar to many adult educationalists but does not appear to have been explored in the context of work-based education about depression, and the people who are responsible for adult education.

In 1988 Sork described ethical quandaries in adult education, one of which was related to basing educational programme content on needs which were unacknowledged by the adult learner, and instead attended to the requirements of employers. Some were even promulgated in a process of social engineering. In the 1990’s the deliberations over the function and purpose of adult educators were examined at length; the question of whether adult educators were tasked with providing services which would empower the individual - as opposed to society in general - were appraised (Baptiste 1999; Kincheloe 1999). In short, the following
question emerged. How could adult educators reconcile potentially tangential concerns of manager-clients (who purchased their educational services for their organisation) and the formal institutions which employed the educators, with those of their adult employee students (Lawler, 1996; Wilson & Cervero 1996)?

In response to these questions, Brockett (1990) and Lawler (1996) had recommended strategies which could be undertaken by adult educators to ensure that they were engaging in ethical practices. These included self reflexivity, examination of personal values and reflection on the ethics of their own practice. Educators were exhorted to find the time for both individual and group reflection about issues of moral principle to enable the identification of ethical dilemmas and conflicts. Brockett also recommended that practitioners undertake critical analyses of the ways in which other professions dealt with ethical dilemmas, and to undertake research into emergent ethical matters in adult education (Brockett 1990).

The context: increasing workplace literacies There is a prevailing demand in Australia - as elsewhere - for adult workers to undertake continuous learning to ensure their economic productivity (Australian National Training Authority 2003). What constitutes the desirable workplace literacies which are identified as integral to such continuous learning - and which may or may not relate to increased productivity - has long been a contentious issue. Street (1985, 1995) proposed that there is an autonomous model of literacy which reflects modernist, logical practice and is exemplified by psychometric testing. By contrast, he states too that there is an ideological model which is characterised by a post modern approach in which context, socio-cultural practice and critical discourse are embedded.

Lonsdale and McCurry (2004, p. 14) took the view that there are three major notions about literacy extant in Australia, which they summarised as:

- A cognitive, individual-based model associated with a psychometric tradition, quantifiable levels of ability, and a deficit approach to 'illiteracy', which is assumed to be both an outcome of individual inadequacy, and a causal factor in unemployment
- An economics-driven model generally associated with workforce training, multi-skilling, productivity, 'functional' literacy and notions of human capital
- A sociocultural model which is most commonly associated with contextualised and multiple literacy practices, a valuing of the 'other', and a strong critical element.

They concluded that:

In general, literacy today is perceived to be social by nature rather than merely an individual's set of skills, and there is consensus among literacy researchers that the meaning of literacy depends on the context in which it is being used. (Lonsdale & McCurry, p14)

In essence them, how you define literacy will be reflected in your responses to perceived social or economic needs.

Depression literacy enters mainstream vernacular As early as 1998, The (Australian) Commonwealth Department of Health and Aged Care (CDHAC) and Australian
Institute of Health and Welfare’s (AIHW) National Health Priority Areas Report (NHPAR) cited both the World Bank and the World Health Organisation as having predicted that by the year 2020, the ‘health burden attributable to neuropsychiatric disorders could increase by about 50 percent...to almost 15 percent in 2020’ (1998, p. 1). In addition to this, the authors found that people in general are not well informed about mental health care and that there is a stigma associated with mental illness. The report clearly identified the need for improvement in the community’s mental health literacy, in the symptoms and disorders and knowledge regarding the availability of options available for people. In relation to this term, in 2003 the Australian Health Ministers cited the researcher, Anthony Jorm, who described mental health literacy as a phrase used to describe:

The ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors for and causes of mental health problems and mental illness; knowledge of self-treatment and of professional help available; and attitudes that promote recognition and appropriate help-seeking (Jorm, 1997, p. 35)

By 2002, Parslow and Jorm had adapted this term to the more specific one of depression literacy, which they described as being:

Community awareness and understanding of depression (“depression literacy”) [which] underpins successful implementation of prevention, early intervention and treatment programmes. Improving depression literacy is a major goal of beyondblue: the national depression initiative. (Parslow and Jorm, 2002, p. 117)

Analogous to the increasing use and understanding of the meaning of the term mental health promotion, the promulgation of the term depression literacy is regarded as educative in that it draws attention to the topic and the concept and will also essentially validate the intention embedded in the term. Given the emphasis on the importance of developing workplace literacies, it is interesting to speculate if depression literacy and mental health literacy will become mainstream workplace literacies.

The framework: responses to increasing identification of depression

Those literacies that are regarded as desirable workplace literacies appear to have been shaped by the increased recognition of the prevalence of mental health illnesses. Of these, depression is currently recognised as a major health concern affecting over 800,000 Australians every year (Henderson, Andrews & Hall 2000; Hickie 2002). In 2001 depression was seen as responsible for the loss of over six million working days annually in Australia (Hickie 2002). Mental health disorders (which include depression) were found to account for almost ten percent of total health systems costs (Australian Institute of Health and Welfare report, 2002). Comparable data has been found in the United Kingdom, Canada, the USA and New Zealand (WHO, 2001).

Workplaces were identified as valuable sites to undertake depression education (Gabriel & Liimatainen 2000; Australian Health Ministers 2003). Depression was
changing from being a private concern of the individual, to one of a whole of
community concern which required a broad, social response.

But what is depression? A confounding problem is the querying across multiple
disciplines about what depression is. In the 21st century, depression appears to have
become an often used description or label which defines particular behaviours and
which is embedded in a psychiatric model. Other social constructions offer some
additional perspectives. Bowers (2000) proposed that the way in which humans
construct their personal realities and their feelings about those realities which may
be affected by a person’s social class, gender or socioeconomic status and so on,
could either reflect or confront the medical model of what constitutes depression).
This explanation has led to some re-evaluation and reframing of the modernist
concepts of a person and to differing perceptions about psychological disorders and
their treatment (Lyddon & Weill 1997; Cox & Lyddon 1997; Hoskins & Leseho 1996;
Rosen & Kuehlwein 1996). Complexities attend current debates about whether
depression as a term has become overused to the exclusion of the term ‘sadness’
(Wolpert 2001; Radden 2002). These definitional problems may further compound
the dilemma faced by adult educators.

National and international responses to levels of depression
In short, inherent in the Australian responses to the information about depression, is
that tension referred to above. For example, some adult educators may experience
problems when charged with facilitating educational activities aimed solely at
promoting worker productivity, with scant attention being paid to those which are
embedded in social altruism. While increasing mental health literacy is at some
levels, expressed as being aimed at reducing stigma and therefore identifiable as
socio cultural action, many of the activities concerning work-based depression
education appear to be marketed to organisations solely on the basis of their
economic desirability.

The following literature details the perceived requirement for increased work-based
and community centred education about depression. It contrasts approaches of
education for economic reasons, to that which is undertaken for reasons of social
altruism. In a 2001 World Health Organisation’s report, it is stated that:

Mental disorders affect the functioning of the individual, resulting in not
only enormous emotional suffering and a diminished quality of life, but
also alienation, stigma and discrimination. This burden extends further
into the community and society as a whole, having far-reaching economic
and social consequences. Mental disorders are often associated with
extended treatment periods, absence due to sickness, unemployment (for
long or short periods), increased labour turnover, and loss of productivity
leading to overall increased costs. (WHO 2001, p. 7)

From the ideological perspective, the destructive nature of the stigma experienced
by people with mental illnesses was regarded by the WHO and the World Psychiatric
Association as a most important issue facing the current mental health field (WHO
2001; Sartorius, 2004). This stigma was identified as taking two forms; one being
the public stigma held against people with mental illness and depression and another
of self stigma, by which the stigmatised person turned against themselves (Corrigan and Watson, 2002).

Jorm and Kitchener (2004) described their trials of a *Mental Health First Aid in the Workplace* programme. They found that attendance at their Mental Health First Aid programme reduced people’s stigmatising beliefs, increased the likelihood that attendees would be comfortable about assisting someone with mental disorders and furthermore, that the mental health of participants actually improved. This approach seemed to be a significant step in the direction of demystifying and destigmatising depression, and potentially encouraging people with depression to seek early assistance.

*The cost benefit approach to marketing anti stigmatising activities* Activities which reflect an underlying modernist, economic perspective are exemplified by the (Australian) Work Outcomes Research and Cost-Benefit (WORC) project. While the researchers in this project intended to identify employees with symptoms of depression who are not in treatment for their symptoms, they state that having been gathering data for a period of time, that ‘the specific aim of this project is to test the hypothesis that the cost of proactive screening and treatment of depression in the labour force’ and that proactive screening:

... improves depressive symptoms, which in turn increases employee productivity resulting in a net benefit to employers and society.  
(University of Queensland, electronic source, n.p.n. 2008)

It would seem likely that the revelation that there are measurable cost benefits to organisations associated with early recognition and treatment of their employees would appeal to some businesses. However, in their research for the WORC project, Whiteford, Sheridan, Cleary and Hilton (2005) found that there was reticence about undertaking work-based mental health education. They had invited Australian Occupational Health and Safety Managers from organisations with greater than 1,000 employees to participate. Of those employers who declined to take part, three primary categories of reasons for declining to participate in an ostensibly free depression screening programme emerged. In rank order, the cost implications to employer were cited as the main reason for declining. The second was that mental health was considered a sensitive topic. The third was that depression was not a management priority. The researchers concluded that the mental health literacy of corporate Australia was poor and that there was a lack of recognition that mental health problems existed. They also concluded that there was a lack of comprehension of the relationship between early intervention and improved employee functioning. They found too that corporate concerns included fear that addressing mental health issues could produce adverse media attention, employee disquiet, litigation and/or health insurance claims against the employing organisation. Furthermore, it was also evident that corporation executives held fears that any identification of mental health investigations could reflect poorly on management practices (Whiteford, Sheridan, Cleary & Hilton, 2005).

Mental health first aid in the workplace courses were rapidly being advertised more widely. In the *West Australian* newspaper in November 2005, in a special feature entitled Health and Safety in the workforce, the assertion was made that:
Most workplaces have staff who are qualified to attend to physical first aid incidents; however, many are unaware how to manage mental health issues. In Australia, approximately 12 million days of productivity are lost each year due to stress leave, unexplained absences and changes in employee behaviour. All mental health disorders have the potential to negatively impact on an employee’s performance and the organisation’s productivity. (West Australian 30 Nov 2005, p. 81)

This article was followed by an advertisement from an organisation which publicised their consultants as being able to conduct Mental Health First Aid Training in workplaces. Advertisements such as these in the mainstream media reflected a developing approach by employment consulting organisations to tap into the appeal of the cost benefits for companies associated with their utilising workplace depression literacy programmes or utilise Employee Assistance services.

Since 2006, an increasing number of workplace-based programmes centred on increasing mental health literacy have been adopted by major organisations. These include several large enough to have the financial, administrative, educational and personnel resources to enable them to undertake work-based education about depression. The organisation beyond blue, a bi partisan initiative of the Australian state and territory governments which aimed to increase knowledge about depression and anxiety disorders, grew rapidly both in its size and public acceptance of its philosophy. In their website bulletin board, beyondblue members described the success of their beyond blue depression in the workplace programme and describe its successful implementation in both the Australian Taxation Office and Work Cover, South Australia (beyondblue 2007a).

In May 2007, the Australian Government Department of Family and Community Services and Indigenous Affairs (FaCSIA) began their roll out of fifty beyond blue workshops on managing depression in the workplace. At that time, FaCSIA was also working with beyondblue to translate the face-to-face workshop programmes into an online e-learning course to extend its scope and accessibility to an increased number of employees. However, as early 1998, Boshier and Wilson (1998) had raised their concerns about the ethical problems of surveillance of on-line education courses, and Holt (1998) raised concerns about the issues of power, access, control, privacy, and equity that could be associated with on line workplace education. Current depression education e-courses do not appear to have been examined in the light of these concerns.

**Conclusion**

In summary, it appears that the dilemma which were acknowledged as inherent in some aspects of adult education in the previous century, are still with us. The notion that mental health or even depression literacy is perceived as new workplace literacy would suggest that what are perceived to be desirable workplace literacies are indeed shaped by social contexts in a post modern world. It is time to revisit the solutions that were examined in the 1990’s in order to ensure that the concerns of the individual educator and recipient of education are not buried in a cost benefit analysis of employee productivity. As recommended by Brockett (1990), we need to encourage and support a familiar but newly framed research agenda about the
ethics of work-based mental health education. Current research can remind experienced practitioners of the recurring dilemma between education for economic imperatives and that for socio-cultural benefit. New practitioners are thereby alerted to ethical issues in adult education, and will know how to access informed strategies which may assist them.

References


This document was added to the Education-line collection on 24 June 2010