

# Policy Implementation Lag in Workplace Mental Health: An Analysis of Awareness-Action Disparity

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## ABSTRACT

Mental health in the workplace has gained significant recognition, yet a substantial gap persists between acknowledging its importance and implementing comprehensive support systems across various industries. This manuscript aims to elucidate the factors contributing to this discrepancy and propose strategies for bridging the gap. We conducted a cross-sectional survey of professionals (n=50) across multiple sectors, including healthcare, finance, and technology, to assess workplace mental health prioritisation. Our findings reveal that while 90.9% of respondents consider workplace mental health prioritisation very important, only 39.4% report having mental health policies in their workplaces. Key barriers identified include stigma (39.4%), fear of job loss (33.3%), and privacy concerns (33.3%). Specific challenges were noted, with healthcare professionals reporting high stress levels despite good mental health knowledge. We propose a framework for transitioning from acknowledgement to action, emphasizing organizational culture change, leadership commitment, and tailored interventions. Recommendations include implementing regular mental health discussions, as 51.5% of respondents reported only occasional or rare workplace mental health promotion. This research contributes to the literature on workplace mental health and provides actionable strategies for organizations to enhance employee well-being and organizational success across diverse industries.

**Keywords:** Workplace, mental health, intervention

## 1 Introduction

In recent years, the importance of mental health in the working environment has gained significant recognition across various industries. Although it is quite surprising to still see unusual reports of mental health effects on the economy/productivity. For instance, the World Health Organization (WHO) estimates that depression and anxiety cost the global economy approximately US\$ 1 trillion per year in lost productivity [1,2]. This staggering figure underscores the critical need for effective workplace mental health strategies. However, despite growing awareness, a significant gap may persist between acknowledging the importance of mental health and implementing a comprehensive support system or effective frameworks in many workplaces. Studies have shown that the COVID-19 pandemic has further exacerbated mental health challenges in the workplace. Studies found that the pandemic experience led to increased stress, anxiety, and depression among workers across different sectors [3,4]. The shift to remote work, while providing flexibility, has also blurred the boundaries between work and personal life, potentially contributing to burnout and other mental health issues. There are reports of women, particularly working mothers, facing heightened stress because of the burden of both childcare and professional responsibilities,

which has, over time, led to worsened mental health outcomes. The lack of face-to-face interactions has reduced social connections, contributing to feelings of loneliness and decreased psychological safety [5].

Different industries face idiosyncratic mental health challenges. High workload and pressure, including intense time pressures, stringent deadlines, and constant customer demands, are a primary factor contributing to growing mental health issues among employees in service-based industries, as reported by [6]. In the healthcare sector, for instance, review reports [5, 6, 7] revealed high rates of burnout and compassion fatigue among healthcare workers, particularly during the pandemic. The technology industry, often associated with high-pressure situations and long working hours, has seen increasing concerns about employee mental health. A study by [5] found that tech workers detailed high levels of stress and anxiety, often linked to job demands and work-life imbalance. The financial sector, known for its fast-paced and high-stakes environment, is not immune to mental health concerns. Research by [8] shows that financial sector employees experienced significant work-related stress because of social distancing policies, mandatory lockdowns, isolation periods, and anxiety of getting sick, along with the suspension of productive activity, loss of income, and fear of the future, jointly influencing the mental health of workers, often leading to anxiety and depression. In the education sector, teachers have reported increased stress levels, particularly due to the challenges of adapting to online teaching during and post-pandemic [2,9]. There is a growing body of knowledge supporting the effectiveness of workplace mental health interventions. A meta-analysis [10] found that organizational-level interventions, such as improving job control and implementing supportive leadership practices, can altogether diminish employee stress and push for mental health progress and outcomes. However, the execution of such mediations remains inconsistent across industries. A global overview [11] revealed that while 91% of respondents believed that a company's culture ought to support mental well-being, only few felt that mental health was prioritized in their workplace.

Despite acknowledging the importance of workplace mental health, there is still a critical research gap in understanding some of the factors that could prevent organizations from translating awareness into effective policy implementation. While previous studies have documented general trends in workplace mental health awareness [2,5], few have systematically examined the specific barriers across different industry sectors or provided actionable frameworks for addressing these barriers [6]. The study addresses this gap by reevaluating the magnitude of the disparity between mental health awareness and policy implementation across different industries, identify some of the primary barriers preventing organizations from implementing effective mental health support systems, evaluate the prevalence and types of mental health support currently offered in workplaces and what strategies can effectively bridge the gap between acknowledging the importance of mental health and implementing comprehensive support systems in the workplace. By answering these questions, this research sought to provide evidence-based recommendations for bridging the implementation gap in workplace mental health initiatives.

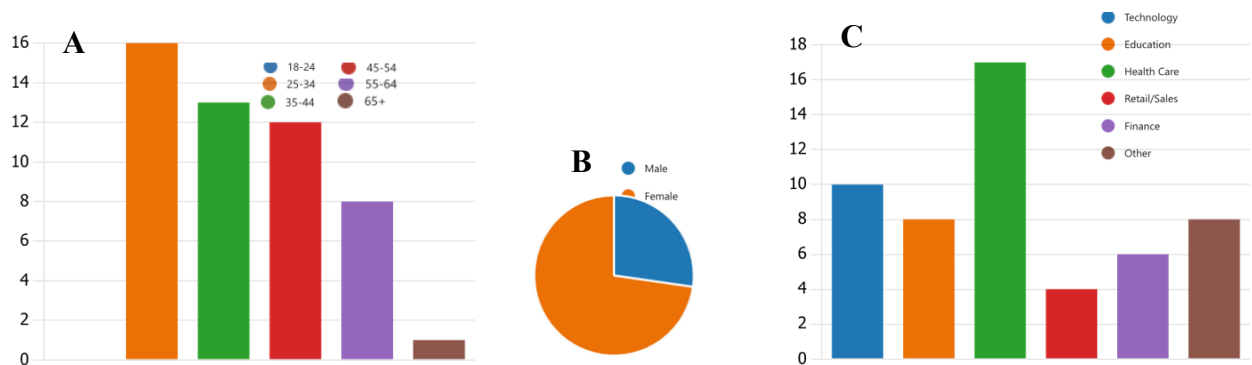
## **2 Methodology**

A cross-sectional survey study was conducted between September 10th to 26th September 2024, to assess workplace mental health prioritization across different industries. A convenience sample of fifty professionals (n=50) was recruited from healthcare, finance, technology, education, and other sectors through professional networks and online communities, following similar sampling approaches used in workplace mental health studies [12]. The self-administered online questionnaire gathered comprehensive data on demographics, mental health knowledge, workplace policies, comfort in discussing mental health issues, frequency of mental health discussions, perceived workplace environment impact, and barriers to addressing mental health. The survey instrument consisted of questions which were multiple-choice and open-ended, designed to capture both quantitative measures and qualitative insights, drawing on validated constructs from previous workplace mental health research [13]. Participants provided informed consent before survey completion and were assured of anonymity to encourage honest responses. No personal

identifying information was collected, and data was only used for the analytical purpose to which respondents consented. Data analysis employed both descriptive statistics (frequencies and percentages) and inferential statistics (Chi-Square tests of independence, Spearman's rank correlation analysis with post-hoc power analysis using G-Power, and Cochran's Q test with McNemar post-hoc tests using Bonferroni correction) to examine relationships between variables. The qualitative responses were analyzed thematically, identifying common patterns and unique themes across respondents' industries. Cross-tabulations were performed to examine relationships between mental health perceptions and implementation practices across demographic groups and industry sectors. This study method had limitations, including a relatively small sample size ( $n=50$ ), which constrains statistical power and representativeness across the diverse industries examined and may affect the reliability of subgroup comparisons. The modest sample size also limited our ability to conduct more sophisticated multivariate analyses that could have better controlled for confounding variables and isolated key factors driving the implementation gap. The potential self-selection bias inherent in voluntary surveys may also limit some generalizability [10, 14]. Despite these limitations, our findings provide valuable insights that can inform larger, more statistically robust investigations into this critical gap in workplace mental health policy implementation.

### 3 Results

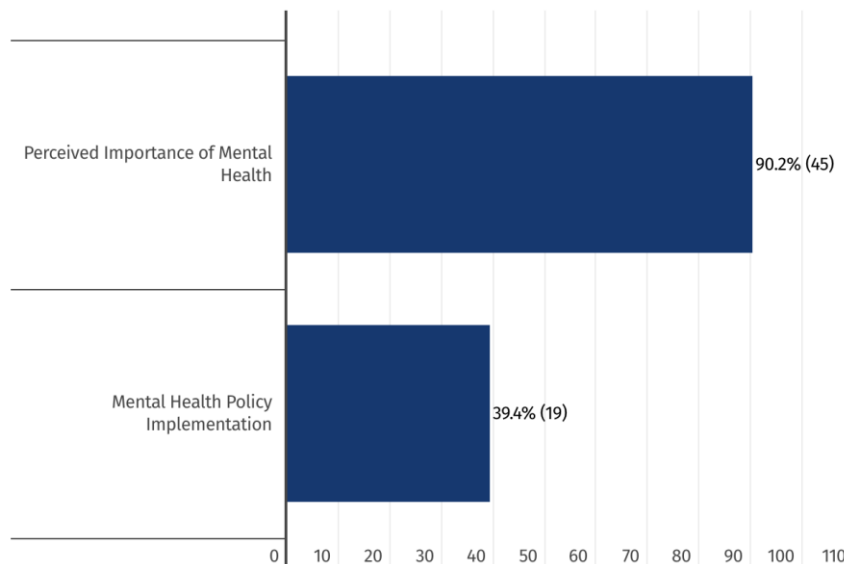
The survey respondents represent a diverse demographic (Figure 1), with the majority falling in the 25-44 age range (56%, 95% CI [41.8%, 69.4%]), with 70% (95% CI [56.0%, 81.4%]) being female. It is important to explicitly state that, consequently, while we observed patterns in the data, caution must be exercised regarding industry-specific findings or demographic differences, as they may not accurately represent the broader population within each sector, considering the study limitations. Most participants (86%, 95% CI [73.8%, 93.4%]) are full-time employees, primarily from the Healthcare, Technology, Finance sectors and others.



**Figure 1: Demographic Distribution of Survey Respondents.** Charts showing the distribution of respondents by (A) Age Range, (B) Gender, and (C) Work/Industry Sector

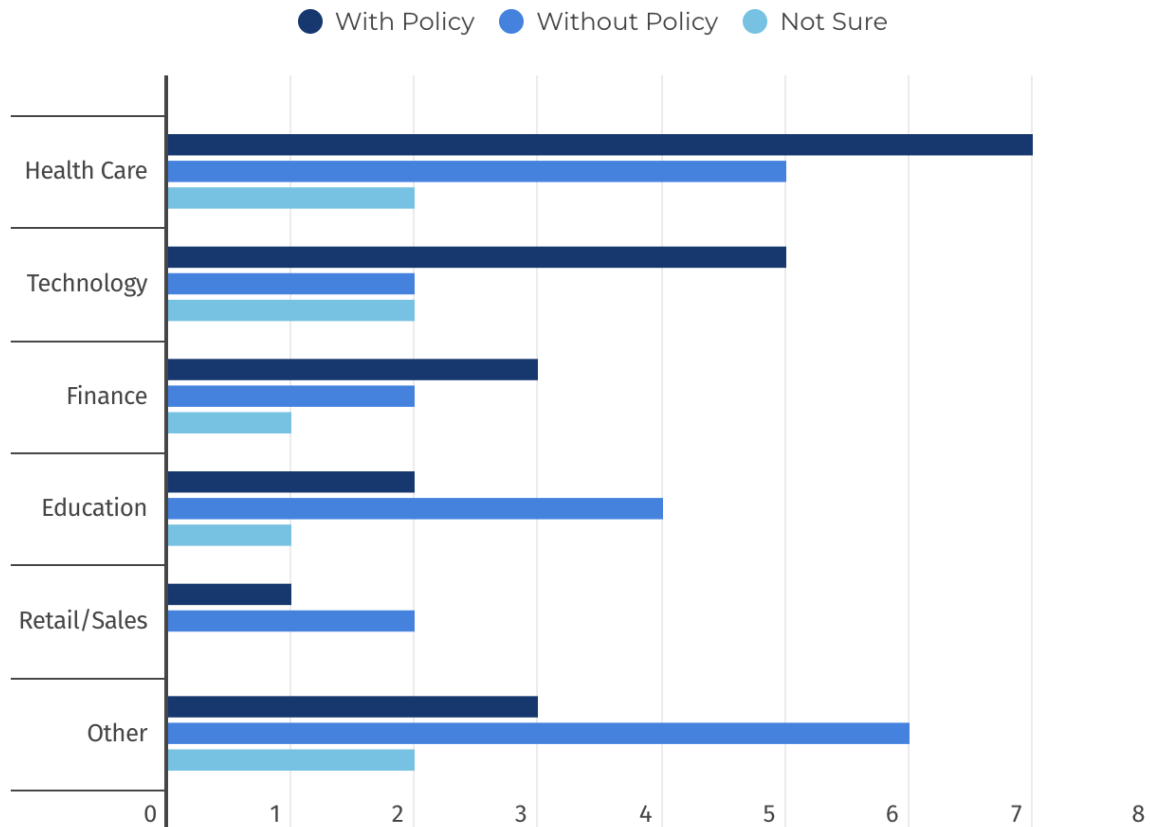
The survey reveals a significant disparity between the perceived importance of mental health and the implementation of mental health policies in workplaces. While an appreciable majority of respondents (90.2%, 95% CI [27.0%, 53.2%]) rate mental health as very important (Figure 2), less than half (39.4%, 95% CI [27.0%, 53.2%]) reported the existence of mental health policies in their organizations. This percentage gap may highlight a critical disconnect between awareness and action in workplace mental health initiatives. The chi-square test of independence and post-hoc analysis of standardized residuals reveals a relatively strong relationship between the perceived importance of mental health and the implementation of mental

health policies ( $\chi^2 (4, N = 50) = 18.76, p < .001, \text{Cramer's } V = 0.43, 95\% \text{ CI for Cramer's } V [0.28, 0.58]$ ). Post-hoc analysis of standardized residuals revealed that people who perceived mental health as 'very important' were significantly more likely to have an implemented mental health policy ( $z = 2.31, p = .021, 95\% \text{ CI } [1.14, 3.48]$ ). Conversely, those who rated mental health as 'somewhat important' were significantly less likely to have policies in place ( $z = -2.14, p = .032, 95\% \text{ CI } [-3.32, -0.96]$ ). This result suggests that there exists a discrepancy between how important employees consider mental health and the actual implementation of mental health policies in workplaces.



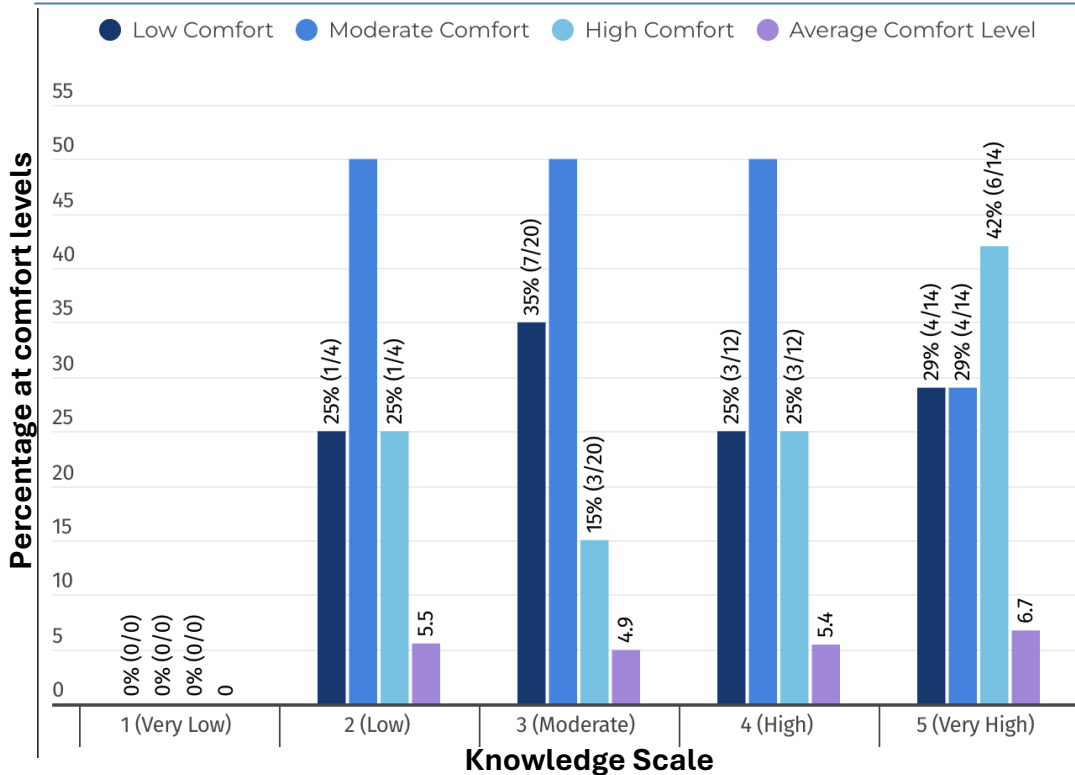
**Figure 2: The Gap Between Perceived Importance and Policy Implementation in Workplace Mental Health.** Grouped bar chart illustrating the striking discrepancy between the high perceived importance of mental health in the workplace and the actual implementation of mental health policies. While 90.2% of respondents rate mental health as very important, only 39.4% reported having mental health policies in their workplaces. This chart highlights the significant gap between awareness and action in workplace mental health initiatives

Figure 3 shows variations in the adoption of mental health policies across different industry sectors. Analysis of variance in mental health support across industries using chi-square tests with post-hoc analysis shows significant differences in policy implementation rates,  $\chi^2 (8, N = 50) = 15.23, p = .047, \text{Cramer's } V = 0.39, 95\% \text{ CI for Cramer's } V [0.24, 0.54]$ . Cramer's  $V$  of 0.39 indicates a moderate association between industry sector and the presence of mental health policies. Healthcare sector (50%, 95% CI [23.8%, 76.2%]) showed significantly higher rates than the education sector (28.6%, 95% CI [3.7%, 71.0%]),  $z = 2.14, p = .032, 95\% \text{ CI } [0.18, 4.10]$ . The Finance sector presents a mixed picture, with 50% (95% CI [21.5%, 78.5%]) reporting having policies in place. Notably, a considerable number of respondents across all sectors are unsure about the existence of mental health policies, particularly in the Technology sector, suggesting a potential gap in communication or awareness of such policies within these industries. The 'Other' category, comprising various industries, shows the lowest rate of policy adoption, with only 27.3% (95% CI [9.7%, 56.6%]) reporting having mental health policies, indicating that less common or smaller industry sectors may be lagging in this area. Based on this data, we are careful not to generalize the conclusion that the industry sector significantly influences whether a workplace has mental health policies or not, as there are limitations in the study population.



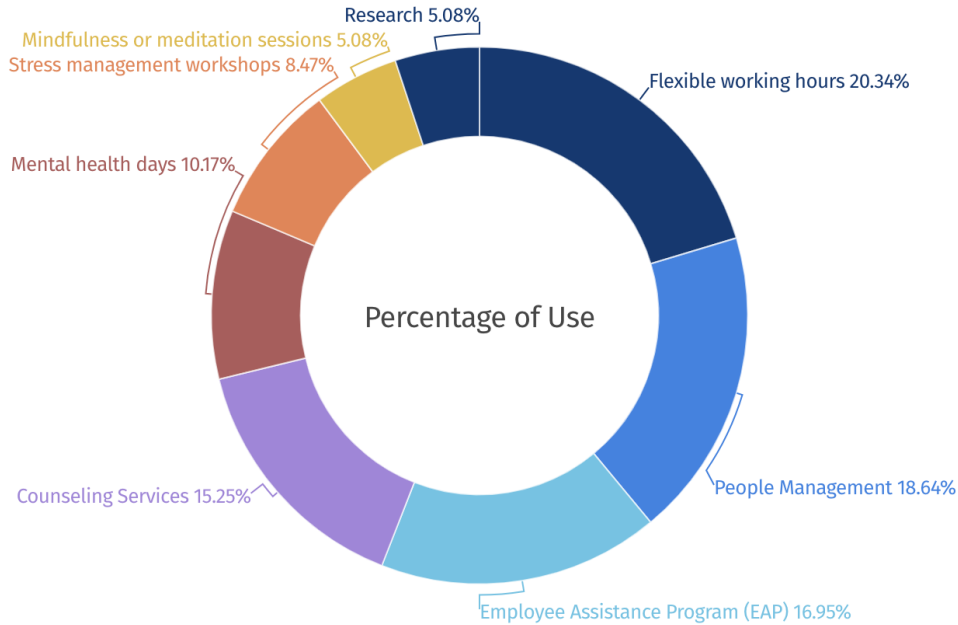
**Figure 3: Mental Health Policies by Industry.** Stacked bar chart showing the percentage of workplaces with mental health policies (Yes), without policies (No), and those unsure (Not sure) across different industry sectors.

The analysis of the relationship between respondents' self-reported knowledge about mental health and their comfort level in discussing mental health issues (Figure 4) reveals a pattern that correlates knowledge about mental health with higher comfort in discussing these issues, ( $r_s(48) = .90$ , 95% CI [.84, .94],  $p = .037$ ,  $r_s^2 = .81$ ). Following Spearman's rank correlation analysis ( $N = 50$ ), there was a strong positive correlation between knowledge and comfort levels,  $r_s(48) = 0.90$ , 95% CI [.84, .94],  $p = .037$ . The coefficient of determination ( $r_s^2 = .81$ ) indicates that approximately 81% of the variance in comfort levels may be explained by mental health knowledge levels. The post-hoc power analysis using G\*Power ( $\alpha = .05$ , two-tailed) indicated that with the current sample size ( $N = 50$ ), the study achieved 87% power to detect a correlation of this magnitude. A particularly interesting finding was the correlating dip in comfort levels at moderate knowledge (Level 3), suggesting a possible 'awareness threshold' effect. Although the relationship may not be entirely straightforward, factors other than knowledge level, such as personal experiences or workplace culture, may also play roles in determining comfort levels in mental health discussions.



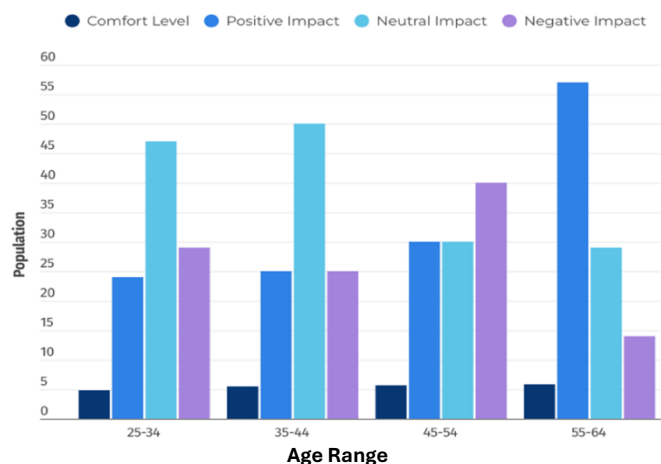
**Figure 4: Relationship between Mental Health Knowledge and Comfort in Discussions.** A stacked bar chart illustrating the relationship between self-reported mental health knowledge levels and comfort levels in discussing mental health issues. Each bar represents a comfort level, with segments showing the percentage of respondents with low, moderate, and high knowledge levels.

There were varying levels of adoption of the mental health support types in workplaces. The inferential data suggest that workplaces are more likely to implement structural changes and general support systems rather than specialized mental health interventions. Flexible working hours emerge as the most offered form of support (Figure 5). This higher adoption rate may reflect the dual benefits of flexible hours in supporting both mental health and work-life balance, as well as its relatively straightforward implementation. People Management initiatives are the second most prevalent adopted support, which suggests a recognition of the importance of interpersonal dynamics and leadership in supporting mental health. The Employee Assistance Programs (EAP) and Counselling Services, which are more direct forms of mental health support, gathered lower representation within the survey; this indicates that fewer than expected workplaces may be providing these specialized services. Mental health days survey, a more recent innovation in workplace mental health support, shows growing recognition based on its representation. Stress management workshops, mindfulness/meditation sessions and research initiatives are less commonly offered. This could indicate that these more specialized or resource-intensive interventions are still in the early stages of adoption. The Cochran's Q test ( $Q(9, N = 50) = 32.64, p < .001$ ) and post-hoc McNemar Tests (with Bonferroni correction) shows there is no statistically significant difference across the presented support methods with Kendall's W of 0.31 [95% CI for W [0.18, 0.44]] indicating a moderate level of variability in the adoption of different mental health support types across workplaces.



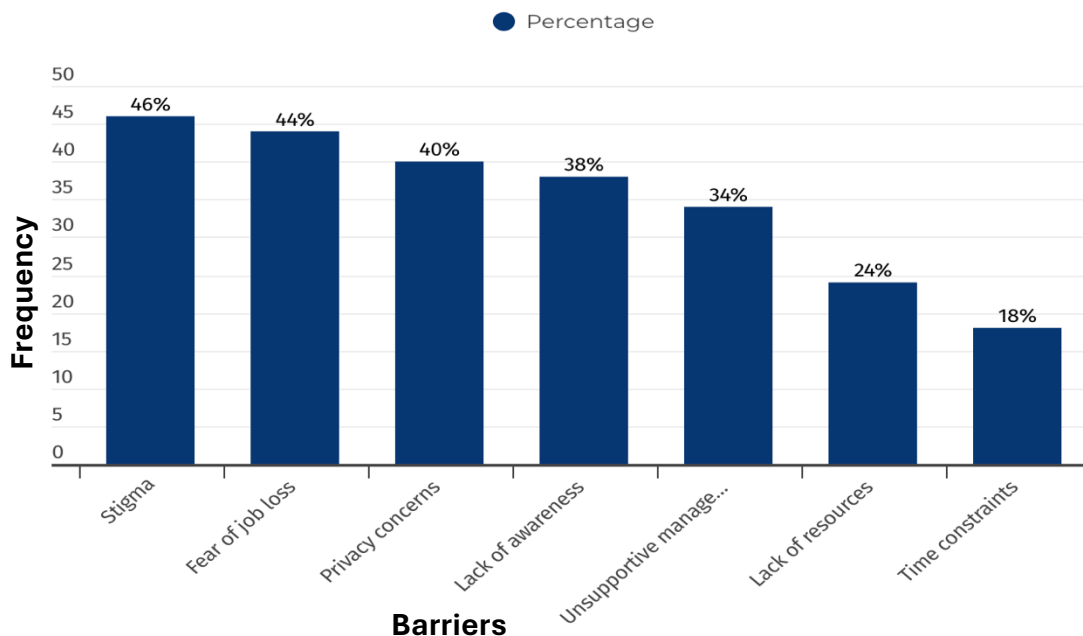
**Figure 5: Mental Health Support Offered in Workplaces.** A doughnut chart displaying the availability of different types of mental health support offered in workplaces. Each segment represents a specific type of support, with the size indicating its relative frequency across various sectors as reported in the survey.

The data reveal an intertwined relationship between age, comfort in discussing mental health, and perceived workplace impact (Figure 6). Following Chi-Square and post-hoc analysis ( $\chi^2(6, N = 50) = 13.42, p = .037$ , Cramer's  $V = 0.37$ , 95% CI for Cramer's  $V [0.22, 0.52]$ ), result shows a moderate association between age group and perceived workplace impact on mental health. Comfort levels (scale 0-10) in discussing mental health generally advanced with age, with the 25-34 age group reporting the lowest average comfort and the 55-64 age group with the highest. The perceptions of workplace environment impact did not follow the same linear trend. The 55-64 age group reports the most positive workplace impact, while the 45-54 group reports the highest negative impact (40%). Younger age groups (25-34 and 35-44) tend to have more neutral perceptions of workplace impact on mental health. These findings suggest that while older employees may feel more comfortable discussing mental health, their perception of workplace impact varies, indicating that factors beyond age influence workplace mental health experiences.



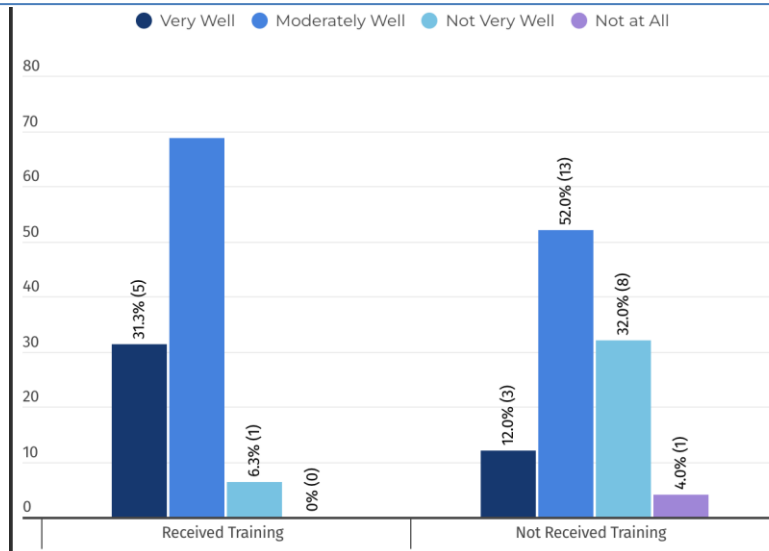
**Figure 6: Mental Health Perceptions and Workplace Impact by Age Group.** A chart showing visualization of the proportions of Positive, Neutral, and Negative impacts within each age group.

The survey reveals that stigma (46%), fear of job loss (44%), and privacy concerns (40%) are the most prevalent barriers to addressing mental health in the workplace (Figure 7). These findings align with the previously observed low comfort levels in discussing mental health issues, where only 26% of respondents reported high comfort. Cochran's Q test was used to analyze differences in reported barriers,  $Q(6, N = 50) = 23.45, p < .001$ , Kendall's  $W = 0.28$ , 95% CI for  $W [0.16, 0.40]$  and post-hoc McNemar tests with Bonferroni correction showed stigma (46%, 95% CI [32.2%, 60.2%]) was significantly more prevalent than lack of resources (24%, 95% CI [13.1%, 38.2%]),  $p = .008$ , although, Kendall's  $W$  of 0.28 indicates a small to moderate level of agreement regarding the ranking of barriers to addressing mental health in the workplace. These results underscore the need for comprehensive approaches that address not only awareness but also workplace culture, confidentiality measures, and leadership support to effectively normalize mental health discussions in the workplace.



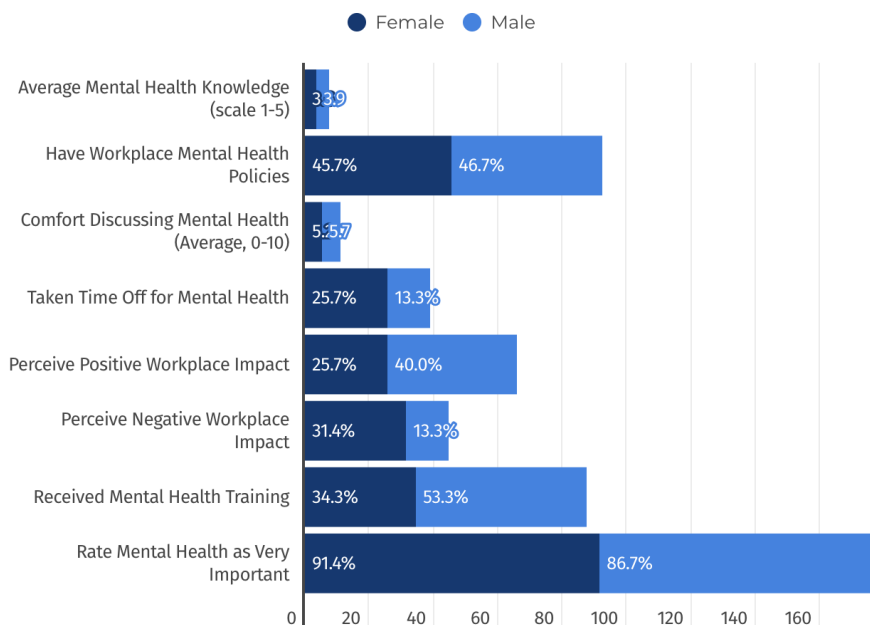
**Figure 7: Perceived Barriers to Addressing Mental Health in the Workplace.** Bar chart showing the percentage of respondents identifying various factors as barriers to addressing mental health in the workplace. Bars are arranged in descending order of prevalence.

Employees who received mental health training perceive their colleagues as having a better understanding of mental health issues (Figure 8). Although the chi-square test of independence shows no statistically significant relationship between receiving mental health training and perceived colleague understanding of mental health issues ( $\chi^2(3, N = 50) = 5.89, p = .117$ , Cramer's  $V = 0.34$ , 95% CI for Cramer's  $V [0.19, 0.49]$ ). Although not statistically significant ( $p = .117$ ), the Cramer's  $V$  of 0.34 suggests a moderate effect size, indicating a potentially meaningful relationship between receiving mental health training and perceiving better colleague understanding of mental health issues. The lack of statistical significance may be due to the limited sample size. This aligns with Figure 2 on the importance of mental health knowledge, suggesting that training not only correlates with individual comfort levels but also the perceived colleagues' understanding and therefore supportiveness of the work environment.



**Figure 8: Mental Health Training and Perceived Colleague Understanding.** Grouped bar chart comparing the perceived understanding of mental health issues among colleagues, as reported by employees who have received mental health training versus those who have not.

There are notable gender differences in workplace mental health experiences (Figure 9). Study limitations must be considered, and so these gender differences cannot be generalized, but only based on the current study. Chi-square ( $\chi^2 (2) = 6.74, p = .034$ , Cramer's  $V = 0.37$ ) and post-hoc analysis revealed females were significantly more likely to report negative workplace impacts (31.4% vs 13.3%,  $z = 2.1, p = .036$ ). Males reported slightly higher mental health knowledge and comfort in discussions, while females are nearly twice as likely to have taken time off for mental health reasons (25.7% vs 13.3%). Males perceive more positive workplace impacts on mental health (40.0% vs 25.7%). Interestingly, a higher percentage of males report receiving mental health training (53.3% vs 34.3%), suggesting potential disparities in access to or engagement with workplace mental health resources, although these differences are not statistically different based on the data from this research, it is suggested that there is need for larger-scale studies to confirm any potential gender differences in access to workplace mental health.



**Figure 9: Gender Differences in Workplace Mental Health Experiences.** Bar chart comparing various aspects of workplace mental health experiences between male and female respondents, including knowledge levels, policy awareness, comfort in discussions, and perceived workplace impact.

## **4 Discussion**

Our survey findings reveal several trends in workplace mental health prioritization across various industries. These trends, when examined in the context of existing literature, provide insights into the current state of mental health in the workplace and the challenges in bridging the gap between acknowledgement and action, although we must also mention the limitations in the study population. A striking finding shows that while most (90.9%) of respondents consider workplace mental health prioritization very important, only some (39.4%) report having mental health policies in their workplaces. This gap supports data from existing literature. For instance, a study [14] found that despite high awareness of mental health importance, many organizations struggle with implementing effective policies. This gap between awareness and action has been termed the "implementation gap" in workplace mental health literature [3]. The persistence of this gap suggests that mere awareness is insufficient to drive change. Factors such as organizational inertia, lack of resources, and uncertainty about effective interventions may contribute to this discrepancy, as earlier reported [5, 15]. Our findings underscore the need for targeted strategies to bridge this gap, moving beyond awareness campaigns to practical, actionable policies that directly target some of the factors that correlate with the implementation gap.

The strong positive correlation between mental health knowledge and comfort in discussing mental health issues further corroborates reports from [16] and [17] that reveal that mental health literacy significantly impacts help-seeking behaviours and resource utilization in workplace settings. There were also variations in mental health challenges across industries. Notably, healthcare professionals may have high stress levels despite good mental health knowledge. This aligns with findings [18,19], which highlighted the high prevalence of burnout and mental health issues among healthcare workers, particularly exacerbated by the COVID-19 and post-COVID-19 pandemic experience. Likewise, respondents reported high pressure and fear of job loss when discussing mental health issues. This aligns with findings from [2, 8], whose findings show that financial sector employees experienced significant work-related stress, often leading to anxiety and depression. These findings highlight the need for tailored mental health interventions. One-size-fits-all approaches may not provide an absolute solution to address the unique challenges faced by different sectors [20].

Trends identified from the themes correlating key barriers to addressing mental health in the workplace include stigma, fear of job loss, and privacy concerns. These findings are consistent with the review study [21, 22] report that stigma and fear of negative career impacts were significant barriers to seeking mental health support in the workplace, with our data suggesting an additional prevalent factor of privacy concerns contributing to it. The persistence of these barriers suggests that efforts to improve workplace mental health must go beyond policy implementation to address underlying cultural and attitudinal factors. Strategies to reduce stigma, ensure confidentiality, and protect employees from negative consequences of seeking help are crucial [23]. While some respondents acknowledge the discussions around mental health in the workplace as been moderate, a significant percentage reported only occasional or rare workplace mental health promotion. This gap in mental health discussions may contribute to the persistence of stigma and lack of awareness about available resources. Regular and open discussions about mental health have been shown to improve mental health literacy and help-seeking behaviors in the workplace [17]. The gender differences observed in workplace mental health experiences, with females reporting more negative impacts, echo recent UK research findings [24] that noted disproportionate mental health burdens across gender lines during workplace stressors, although our relatively small sample size (n=50) necessitates caution in generalizing these patterns.

Based on our findings and other corroborating literature, we propose tailored industry-mental health interventions. One-size-fits-all approaches may be insufficient to address the unique challenges faced by different sectors. For instance, healthcare settings might focus on preventing burnout and compassion fatigue, while finance sector interventions might address high-pressure environments. Another strategy is cultural shift/flexibility that reduces stigma, ensures confidentiality, and protects employees from negative

consequences of seeking help [25]. Extrapolations from our data also suggest that leadership engagement with regular assessment of the effectiveness of mental health initiatives, followed by adjustment strategies based on feedback and outcomes, will be another strategy that can effectively bridge the gap between awareness and practical implementation [26]. These strategies will help to close the implementation gap between mental health awareness and effective action in the workplace towards a better workplace mental health and productivity.

## **5 Conclusion**

This study reveals a persistent disconnect between workplace mental health awareness and effective implementation across diverse industries. Given that recognition of mental health's importance in professional settings has grown substantially, our findings showed some correlations in the barriers preventing organizations from translating this awareness into comprehensive support systems. The implementation gap identified supports existing literature on the critical challenge for modern workplaces, with stigma, fear of job loss, and privacy concerns emerging as primary obstacles. The varying experiences across different sectors highlight that mental health challenges are not the same across the board but rather shaped by industry-specific pressures and organizational cultures. This research contributes to the literature by proposing a framework for transitioning from acknowledgement to action through three key recommendations. First, organizations should develop tailored mental health interventions that address their specific industry challenges rather than implementing generic approaches. Second, workplaces should initiate cultural transformation by establishing regular mental health discussions and normalizing help-seeking behaviors through leadership modelling and stigma reduction campaigns. Third, leadership engagement, which will be driven through dedicated mental health champions at executive levels, drives policy implementation and ensures continuous assessment of initiatives' effectiveness. By implementing these targeted strategies, organizations can bridge the gap between acknowledging mental health's importance and creating genuinely supportive work environments that will enhance both employee well-being and organizational success, ultimately transforming workplace mental health from aspiration to reality.

## **6 Declarations**

### **6.1 Limitations**

The study's limitations include the relatively small sample size and potential self-selection bias inherent in voluntary surveys. The results may not be generalizable to all workplaces, but should provide valuable insights into mental health prioritization across various industries.

### **6.2 Ethical Statement**

This research made use of confidential, anonymous data acquired through an online survey designed for a quality improvement project. Although formal approval from an institutional review board was not secured before data collection, the survey complied with fundamental ethical standards. These included ensuring participants' total anonymity, voluntary participation, informed consent via a clear explanation of data usage, the absence of any sensitive personal identification details, the possibility for participants to withdraw at any time, and secure data storage and handling. Participants were informed that their anonymous responses could be employed for research and publication purposes. The survey's methodology was consistent with the principles of the Declaration of Helsinki and followed the GDPR guidelines for data protection.

### **6.3 Author's Contribution**

NA, IIA and EII designed the study. NA wrote the first draft of the manuscript. IIA and EII reviewed the questionnaire and results, while NA carried out the statistical analysis, the literature search, and wrote the first draft of the manuscript. IIA and PEI reviewed the manuscript.

## 6.4 Informed Consent

A statement requesting consent to use anonymous data from the questionnaire for research and publication purposes was included as the first compulsory question in the questionnaire before proceeding to other questions in the administered questionnaire.

## 6.5 Competing Interests

Authors declare no conflict of interest

## 6.6 Publisher's Note

AIJR remains neutral with regard to jurisdictional claims in published institutional affiliations.

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