STIGMA TOWARDS INJURED OR ILL WORKERS

Research on the causes and impact of stigma in workplaces, and approaches to creating positive workplace cultures that support return to work

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Contents

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Executive summary

Background

Workplace injury/illness stigma refers to a process of negative stereotyping or labelling of a worker with a stigmatised condition (i.e., an injury/illness that carries social disapproval because it is perceived as undesirable, threatening, or problematic) and is typically followed by adverse social repercussions, such as discrimination, ostracism, or differential treatment.

Workplace stigma towards injured and ill workers is a psychosocial hazard that can interfere with injury management processes, and even contribute to secondary or worsening psychological conditions. In Australia, stigma is one factor that may cause workers to be hesitant to disclose injuries and illnesses, claim less than they are entitled to, and/or expedite the return-to-work process or overcompensate for their condition.

The problem of workplace stigma

Stigma exists in many Australian workplaces. In the most recent National Return to Work (NRTW) Survey conducted by Safe Work Australia (2018), approximately one-third of workers anticipated a negative repercussion from colleagues in response to disclosing a workplace injury or illness. Just over 15% of survey respondents stated that their employer would actively discourage injury or incident claiming/reporting, highlighting the salience of stigma in some workplace settings. Importantly, this type of stigma can complicate the return to work and recovery trajectory of injured/ill workers (Kirsh et al., 2012). Our research identified that other adverse outcomes of stigma may include reduced health and wellbeing for workers, concealment of injuries and incidents, premature or failed return to work, and increased use of sick and annual leave entitlements.

Work health and safety (WHS) laws require a person conducting a business or undertaking (such as an employer; PCBU) to provide a safe workplace, which includes the provision that they must eliminate or minimise risks to psychological health, so far as is reasonably practicable. Ensuring processes are in place to support an environment where everyone can confidently identify and raise WHS issues helps to create a safe and mentally healthy workplace.

Using a preventative risk management approach when designing and planning processes and policies is beneficial as it is more effective to eliminate hazards before they are introduced into a workplace.

The business case for reducing stigma

In the injury management space, correlational and qualitative evidence suggests a raft of positive benefits when stigma is managed effectively. By reducing the occurrence and experience of stigma in workplace injury/illness settings, organisations may be more likely to achieve improved employee wellbeing, increased incident reporting (providing more information about how to reduce incidents preventatively), and more efficient recovery and return to work outcomes. Stigma creates a compounding negative effect outside the injury management and workers' compensation space. Bullying and harassment typically accompany stigma, and organisations are more likely to experience legal challenges such as civil law claims in stigmatised environments. Stigma may also reduce trust between workers and managers, which can adversely impact work performance. Consultation with industry leaders has revealed that organisations can achieve reductions in workers' compensation insurance premiums by addressing stigma through the activities described in this report.

Scope and objectives of this project

The objectives of this project included:

1. Undertaking research on the causes of stigma relating to workplace injury and illness, workers' compensation and return to work, and the impact stigma has on workers.
2. Development of recommendations for practical application of this research in national messaging for workers and in guidance for employers to address workplace stigma.

Also in this project, we focus on injuries/illnesses that occur at work, with non-work related injuries and illnesses being out of scope.

Research Questions

This project was guided by four key research questions. The questions were answered through the project activities and summarised by the deliverables. The research questions included the following:

1. What are the primary causes of stigma in the workplace relating to work-related injury and illness, workers' compensation and return to work?
2. How does workplace stigma impact workers' willingness or ability to disclose their work-related injury or illness, make a claim, and be confident to participate in their own recovery and return to work?
3. What protective workplace factors and organisational actions are effective in shifting negative perceptions and destigmatising work-related injury and illness,

workers' compensation and return to work? And how can these factors and actions be broadly promoted to and put into practice by employers?

4. What initiatives have been effective to shift negative perceptions and promote equality and inclusiveness in other areas of society (e.g., sport, mental health, HIV)? And how could learnings from these initiatives translate to the workplace to create a positive workplace culture that supports workers to disclose their injury, make a workers' compensation claim and return to work?

Approach

The approach included two main lines of inquiry: academic research and industry consultation. Details of the project method are summarised below.

Academic research

- A literature scan of the workplace stigma literature generally, focussing on peer-reviewed articles published within the last 10 years.
- A systematic review of workplace stigma reduction interventions.
- A literature scan of six different stigma research domains (i.e., sport, criminality, welfare, diversity and inclusion, LGBTI+, and chronic disability).
- Interviews with five academic experts in the areas of mental health stigma, physical disability and rehabilitation, work design, and injury management.

Industry consultation

- Desktop research conducted on workers' compensation regulator websites and various Safe Work Australia reports and publications.
- Consultation with 11 industry leaders, and focus groups conducted with WHS and workers' compensation regulators for each jurisdiction.
- A survey of 150 HR practitioners regarding stigma reduction initiatives in their organisations.

Project findings

Our research suggests that the most efficient and cost-effective way to reduce stigma is by creating a supportive, inclusive, and mentally healthy workplaces. Our review has revealed robust empirical evidence on the positive effect of these culture initiatives and associated organisational developmental activities and practices. For example, the benefits of mentally healthy workplaces free from stigma are well-established in Australia, with a significant positive return on investment for mental health initiatives (see PwC, 2013). More broadly, developing an inclusive and supportive workplace that embraces diversity has also been shown to contribute to workplace performance such as turnover, innovation, and productivity (Martins, 2020; Milliken & Martins, 1996). Further outcomes realised from a diversity supportive and inclusive culture include organisational value, productivity levels, and overall profitability (Jiraporn, Potosky & Lee, 2019; Pichler et al., 2018).

Recommendations

Recommendations were developed by integrating evidence across literature with the results of consultation. Priority recommendations were identified by selecting those with multiple strong sources of evidence across both academic and industry domains.

Recommendation 1 – Build leadership capability

Organisations should improve leaders' health and well-being literacy through awareness, training, and guidance material to reduce stigma.

Recommendation 2 – Implement formal policies and procedures to reduce stigma

Organisations should consider implementation of formal policies and procedures to embed practices that aim to reduce stigma.

Recommendation 3 – Change cultural attitudes towards injured workers

Organisations should consider incorporating stigma awareness and prevention strategies through existing policies and procedures.

Recommendation 4 – Monitor the effectiveness of stigma reduction strategies

Organisations should consider the development of measurement frameworks to monitor the prevalence of stigma within the organisation and the effectiveness of stigma reduction strategies.

Recommendation 5 – Raise awareness of the impact of stigma in the workplace

Policy makers, Insurers and Workers Compensation Authorities should consider the development of awareness campaigns and guidance material for employers on the adverse impact of Stigma in the workplace.

Recommendation 6 – Undertake further research on behaviours impacting workplace stigma

Policy makers, Insurers and Workers Compensation Authorities should consider undertaking further research to better understand behaviours relating to stigma arising from workplace injury/illness to extend research done on attitudes and intentions.

Recommendation 7 – Improve data collection of the impact of stigma

Policy makers, Insurers and Workers Compensation Authorities should consider improving data collection of the impact of stigma on injured workers through existing national surveys to assist employers, workers' compensation and work health and safety regulators with understanding the impact of existing policies and changes over time.

Chapter 4 contains more detailed descriptions of the recommendations and summarises the levels of evidence that informed each one.

Conclusions

Overall, this project revealed that although stigma in general social science research is an established area of study, little published work has yet been done on how stigma operates and affects workers disclosure, claiming practices, and recovery/return to work. Instead, stigma research has been incorporated into general health and wellbeing studies. As a result, the business case for stigma reduction is indirect and tied to more general evaluation research such as the development of healthy, inclusive, and supportive workplaces.

Published research on intervention tends to focus on contact-based and education-based activities that seek to reduce stigma toward mental health problems.

There are three main areas we believe will lead to effective outcomes for stigma reduction into the future. Insurers and regulators can encourage organisations to collect and share empirical evidence of the impact of their health, wellbeing, and organisational development activities on workplace stigma. Universities could also be involved in this process to ensure rigour in data collection and analysis. Stories of success must also be collected and recognised through awards at national and jurisdiction-level events such as network groups and industry forums. Finally, there is an opportunity to examine how stigma reduction interventions can work synergistically to enhance the intensity and impact of other organisational initiatives.

Chapter 1: Introduction

In 2018-19 there were 114,435 serious workplace injury and illness claims lodged in Australia, and between 2000 to 2018, the median time lost for a serious claim rose by 48% to 6.2 working weeks. (Safe Work Australia, 2021). These statistics highlight the growing need for supporting workers to rehabilitate and recover. Throughout Australia, workers' compensation systems are designed to provide care, support, and rehabilitation to facilitate the recovery of injured/ill workers, and so ease the burden on individuals, employers, and the community.

One problem faced by injured/ill workers during rehabilitation and recovery is stigma—a process of inherent or intentional negative labelling and subsequent discrimination that dominates, controls, or disadvantages an injured/ill worker. Stigma affects all aspects of the workers' compensation process, beginning with disclosure (inhibiting speaking up due to inherent fear or anxiety about stigmatisation), making a claim (limiting the extent of benefits sought and paid to facilitate recovery) and finally, returning to work (increasing the likelihood of premature return and over-exertion to compensate for perceived inadequacies and/or burden on the organisation).

Overall, stigma reduces the efficiency, cost-effectiveness, and positive health impact of workers' compensation systems in Australia. It also makes workplaces less inclusive to the different abilities and experiences of the Australian workforce and can lead to unfavourable treatment. Stigma also risks employers not adhering to work, health and safety (WHS), equal opportunity, and anti-discrimination obligations at state, territory, and federal levels. Broadly, there are opportunities to understand how stigma interplays with various statutes.

Extent of the problem

National statistics highlight that not all workers disclose their injuries/illnesses, some continue working despite the presence of serious injuries (e.g., chronic musculoskeletal disorders, cuts, and open wounds), and some choose not to report their condition to their supervisor or employer (Australian Bureau of Statistics, 2018).

Importantly, findings suggest that stigma may play a role in exacerbating barriers to effective rehabilitation and recovery. The National Return to Work survey highlights stigma in workplace injury/illness settings. In 2018, 32.2% of respondents said that they would be treated differently by people at work, 22.0% stated that a supervisor thought the respondent was faking or exaggerating their condition, 21.5% were concerned that they would be fired for submitting a claim, and concerningly, 15.6% reported that their employer actively discouraged a claim (Safe Work Australia, 2018). Stigma can even complicate the return to work and recovery trajectory of injured/ill workers (Kirsh et al., 2012).

Stigma towards injuries and illnesses appears to vary in intensity according to the type of condition; for instance, in the same survey, 72.4% of workers perceived that they would be treated differently by other people at work if they had a mental illness, compared to 21.9% of workers if the injury was a bone fracture (Safe Work Australia, 2018). Other research (Pachankis et al., 2018) has found that experiences of stigma vary according to criteria such as visibility of the injury/illness, controllability and impact on work performance, and perceived personal responsibility (with some conditions attributed to the actions of the worker, and therefore more stigmatised). The intensity of stigma also depends on individual (socio-economic and demographic) and team-related factors (supportive leadership) and organisational factors (inclusive culture) (Thompson & Grandy, 2018). Clearly, stigma towards injured and ill workers is a significant and complex issue.

Following on from these results, stigma towards injury and illness can create broader problems for employers, which are explained in the next section.

Rationale for action

Although the problem of stigma in workers' compensation system settings generally is well-established, little work has been done to integrate current research and summarise the recommendations and methods of successful stigma reduction programs. Most prior research tends to be qualitative and describes the experiences of workers navigating workers' compensation and rehabilitation processes.

Public awareness of stigma and its adverse effects tends to be low in Australia (Groot et al., 2020). Employers may struggle to understand the nature of stigma and suffer from low insight around how their actions may exacerbate existing injuries/illnesses or contribute to new problems through inadvertent labelling and stereotyping, or overt expressions of social control such as discouraging claims and hastening the return-to-work process due to financial concerns.

The benefits of mentally healthy workplaces free from stigma are well-established in Australia, with a significant positive return on investment for mental health initiatives (see PwC, 2013). More broadly, developing an inclusive and supportive workplace that embraces diversity has also been shown to contribute to workplace performance such as turnover, innovation, and productivity (Martins, 2020; Milliken & Martins, 1996). Further outcomes realised from a diversity supportive and inclusive culture include organisational value, productivity levels, and overall profitability (Jiraporn, Potosky & Lee, 2019; Pichler et al., 2018). This evidence supports an integration approach to stigma reduction, through expanding broader conversations and organisational development activities that improve stigma by creating supportive, inclusive, and mentally healthy workplaces.

Although no robust research has yet been done that empirically associates stigma reduction activities with specific business outcomes, correlational and qualitative evidence suggests a raft of positive benefits. By reducing the occurrence and experience of stigma in workplace injury/illness settings, organisations may be more likely to achieve improved employee wellbeing, increased incident reporting (providing more information about how to reduce incidents preventatively), and more efficient recovery and return to work outcomes. Importantly, our consultation with industry leaders revealed that these organisations have achieved reductions in workers' compensation insurance premiums by addressing stigma through the activities described in this report.

Project overview

This project supports Safe Work Australia's National Return to Work Strategy 2020-2030 through operationalising Action Area 2, which concerns building positive workplace cultures and leadership capabilities. This project began with the premise that workplace social relationships, including attitudes and behaviours, affect the trajectory and outcomes of injured/ill workers. The project was also founded on the notion that stigma negatively impacts the disclosure of injury/illness, inhibits claims engagement, and reduces the effectiveness of recovery and return to work processes.

Objective and aims

The objective of this project was to clarify the nature of stigma in workplace injury/illness settings, with a focus on its causes and effects. We also sought to identify useful and practical ways that organisations can reduce stigma through activities that contribute to a supportive organisational culture.

This objective was supported by several aims. One aim was to develop a clear and straightforward definition of workplace injury/illness stigma. Another was to summarise the evidence regarding the causes and outcomes of stigma, as well as the psychological processes involved. A final aim was to collate evidence of workplace interventions, including research from other non-workplace domains, that can reduce stigma and develop evidenced recommendations that can guide policy, communications, and guidance from Safe Work Australia.

Research questions

The project was guided by four key research questions. These questions were answered through the project activities and summarised by the deliverables. The research questions included the following:

1. What are the primary causes of stigma in the workplace relating to work-related injury and illness, workers' compensation and return to work?
2. How does workplace stigma impact workers' willingness or ability to disclose their work-related injury or illness, make a claim, and be confident to participate in their own recovery and return to work?
3. What protective workplace factors and organisational actions are effective in shifting negative perceptions and destigmatising work-related injury and illness, workers' compensation and return to work? And how can these factors and actions be broadly promoted to and put into practice by employers?
4. What initiatives have been effective to shift negative perceptions and promote equality and inclusiveness in other areas of society (e.g., sport, mental health, HIV)? And how could learnings from these initiatives translate to the workplace to create a positive workplace culture that supports workers to disclose their injury, make a workers' compensation claim and return to work?

Project findings

Origins of stigma

Stigma has an evolutionary basis because latest research suggests that stigma may have increased the chances of survival in group settings. Stigma continues to be experienced today due to it being an embedded part of human psychology. Specifically, stigma can stem from a deeply internalised drive to find valuable and cooperative partners, avoid infectious diseases, and prevent individuals from exploiting group resources.

Process of stigma

Importantly, although stigma seems to be an automatic process, the negative stereotypes that drive stigma evolve over time, as broader societal beliefs and attitudes change in step with broader efforts to reduce discrimination and inequity. Stereotyping that lies at the core of stigma can be mitigated by encouraging workers to challenge deeply held beliefs and operate from deliberate and purposeful thinking styles.

Groups with higher social status or influence can exert their power over injured or ill workers to maintain the status quo, such as passing over an injured worker for promotion opportunities or discouraging them from making a workers' compensation claim. Such power plays ultimately derive from a conflict of interest or tension between the needs of the injured or ill worker, and the desire of stakeholders to maintain control (e.g., over spiralling costs, organisational competitiveness, or productivity). In an organisational setting, stigma can be used to exert influence over or constrain the actions of others in less advantaged positions.

Impact of stigma

Stigma carries significant negative effects on workers who become injured or ill at work. These adverse effects on workers can be divided into three areas: cognitive, emotional, and behavioural. Cognitively, an injured worker becomes aware of stigma, and this affects their thinking about the organisation (reducing engagement and commitment). Emotionally, injured workers experience fear, anxiety, and internalisation of stigmatised attitudes. Behaviourally, workers can elect not to speak up, claim more or less than they are entitled to, and either return to work too early or take excess leave.

For employers, consultation with industry leaders revealed that stigma may drive increased insurance premiums and other associated costs. This financial impact seems to be driven by delayed or concealed reporting of injuries and illnesses (exacerbating their intensity and the cost of treatment), perceptions of malingering or inauthenticity that in turn drive adversarial relationships between workers and managers, and either premature or delayed recovery and return to work. Over the long-term, organisations may suffer financially through workforce disengagement and reduced productivity, counterproductive work behaviours including active deviance, and increased workers' compensation insurance premiums.

Addressing stigma

Interviews and a survey of managers and business owners in Australia conducted for this project showed that many organisations have stigma on their agenda. Interviews with industry leaders (identified through insurers' and WHS regulators' annual awards programs and professional networks) revealed that many organisations are integrating stigma reduction initiatives within existing broader activities such as diversity and inclusion, mental health and wellbeing, and general organisational culture development. Survey data se collected during this project confirmed this result, with 57% of respondents agreeing that their organisation had already or was planning to conduct stigma reduction initiatives.

Peer support programs, leadership development activities such as supportive conversations training, and preventative wellbeing support programs (e.g., proactive use of employee assistance programs, critical incident debriefings, welfare/wellbeing checks, and psychosocial risk reduction planning) were the most prevalent interventions disclosed by industry. Regarding barriers to implementing stigma-reduction initiatives, external influences such as the effect of the pandemic and changing market conditions, lack of senior management support, and inadequate internal capability to design and implement effective interventions were commonly raised.

A resounding theme from our consultation was that engaging in stigma-related conversations and reduction initiatives does not encourage malingering or increased costs for employers.

Evidence-based and effective actions that our research identified to address stigma span six domains: inclusive organisational culture, supportive leadership, health literacy programs, formal polices and procedures, peer support groups, and direct psychological support for injured/ill workers. Each of these domains is expanded briefly below.

Inclusive organisational culture. Employers have a responsibility to set the behaviour standards that provide a safe workplace for all workers. The workplace should foster a healthy and respectful work culture where poor behaviour is not tolerated. Workplace culture and behaviour standards that are implemented to prevent poor workplace behaviour play a key role in addressing harmful behaviour early, ideally before it escalates. Fostering a supportive and inclusive organisational culture carries positive effects on stigma reduction. Overall, a ‘community’ oriented culture that emphasises employee relationships, development and training, and incorporation of support, care, and communication within performance systems is a way to mitigate stigma and also achieve broader organisational benefits beyond improved disclosure, claiming, and recovery/return to work (i.e., improved wellbeing and productivity).

Health literacy programs. Research has shown that stigmatised attitudes and intentions can be changed through brief and efficient interventions that focus on exposure to persons with lived experience and health and wellbeing literacy. General lecture-based psychoeducation about health and wellbeing topics, and interventions such as contact exposure and group discussion about stereotyped attitudes and beliefs are effective at shifting attitudes in the short-term, but little is known about the impact on actual behaviour after training.

Formal policies and procedures. A workplace policy can help set clear expectations about behaviours in the workplace and during work-related activities and also provides important information for workers, supervisors and managers around what is required of them. Policies that promote inclusivity and equality create a foundation that reduces stigma. Formalisation of requirements and standards creates the expectation that acceptance of differences among employees, a fundamental component of reducing stigma, is part of the organisation's values and priorities. Workplace policies should be developed in consultation with workers and their representatives. All workers must be made aware of the relevant policies and behaviour standards expected of them.

Peer support groups. Although many organisations are implementing peer support programs, evidence suggests that these resources can be particularly effective at mitigating stigma. In particular, where these peers are persons with lived experience of injury and illness at work, they can offer direct psychological support and advice about what to expect, how to deal with the injury/illness experience, and clarification of injury management processes.

Direct psychological support services. Evidence suggests that when injured or ill workers are offered counselling and other psychological support services, this can reduce the impact of stigma. Self-stigma is a particular psychosocial hazard for workers involved in an injury management process. Counselling assists workers to externalise these beliefs and challenge them through evidenced practices like cognitive behavioural therapy.

Outputs

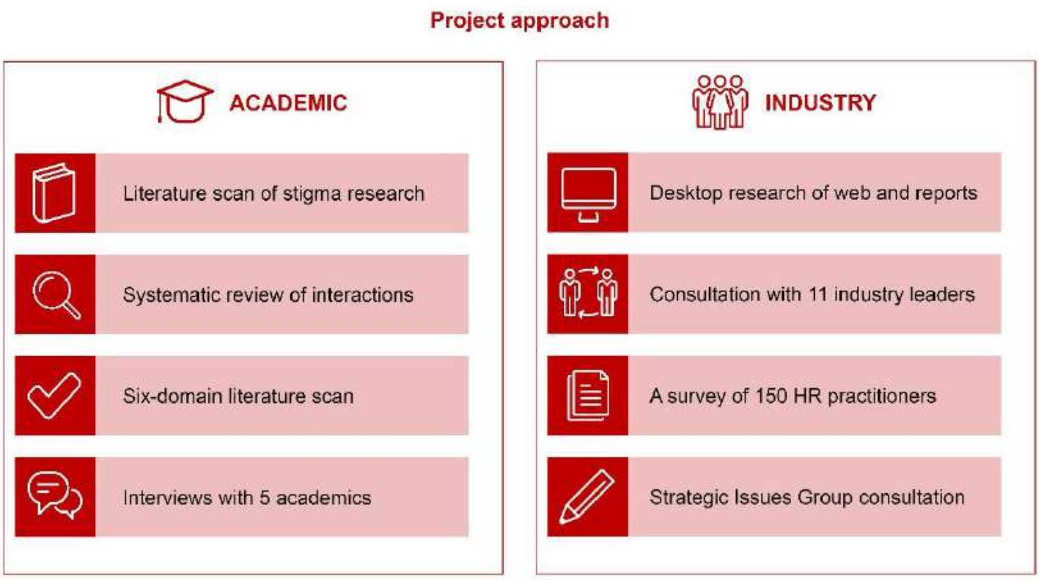
Outputs from this project included the development of evidence-based recommendations for organisation-level actions and activities to reduce stigma towards injured/ill workers, aligned with various stakeholders and how they can support such actions (e.g., WHS regulators, unions, associations). We also developed suggested communication topics and messages, and a brief agenda for future research on injury/illness related stigma.

Approach

Our approach began with a literature scan of highly cited and influential peer-reviewed articles on stigma broadly, and in relation to injury/illness stigma specifically. The purpose of this literature scan was to develop a specific definition of stigma, outline its origin and development including causes, and map the outcomes. We then conducted a systematic review on injury/illness-related intervention research and summarised the evidence around various stigma reduction activities. Thirdly, a cross-domain (across six different topic areas) was undertaken, with a view to informing further insights into injury/illness-related stigma.

Consultation was done in four phases. First, we engaged with 11 human resources (HR) and WHS managers from organisations identified (i.e., through WHS regulator awards, word-of-mouth, and referrals from professional networks) as leaders in stigma reduction. We then consulted with five esteemed academics in injury management and stigma reduction. Thirdly, a smaller group of HR professionals and regulators were engaged to help us expand and interpret the initial set of findings. The final step in our consultation strategy involved two focus groups with Strategic Issues Group (SIG) members (comprised of representatives from each of the state and territory WHS regulators, and state insurer regulatory bodies). Figure 1 shows a schematic of the project approach.

Figure 1. Schematic of the project approach.



Report structure

This report includes five chapters, an attachment, and an appendix, which are described below.

- Chapter 1 outlines the core problem to be investigated, and justifies the project along with outlining the scope, approach, and outputs.
- Chapter 2 presents a summary of the nature of workplace injury/illness stigma, its causes, and effects.
- Chapter 3 summarises the evidence for workplace protective factors and stigma reduction initiatives, drawing on the findings of all project deliverables.
- Chapter 4 describes the recommendations for action summarised across three areas of integration with existing initiatives and processes, and recommendations for supporting stakeholders such as policy makers, insurers and workers compensation authorities.
- Chapter 5 offers concluding thoughts and implications.
- Attachment A – Guidance for employer communication and engagement
- The Appendix contains the detailed methods and protocols surrounding the systematic literature review, consultation, and HR practitioner survey.

Chapter 2: Stigma towards injured/ill workers

Workplace injury/illness stigma is a process of negative stereotyping due to a worker being injured or falling ill. Broadly, stigma is the tendency within a workplace setting to act in a discriminatory manner towards people with a work-related injury or illness. This process may be 'automatic' and subconscious, or purposeful to disadvantage or control another person. Where there are differences between groups of people and an imbalance in power/influence, stigma is more likely to occur. The purpose of worker stigmatisation, when enacted with intent due to power imbalances, is to differentiate them from other employees and exert a negative influence over their disclosure, claiming, and/or return to work behaviour (e.g., discourage a worker from speaking up about their condition, reduce or avoid claims, or returning to work faster than is healthy or appropriate).

In this chapter, we explore the causes and basis of workplace injury/illness stigma, as well as its outcomes on the individual worker, teams, and the organisation. 'Amplifying factors' that accentuate the effects of stigma in some situations are also described.

The evolutionary basis of stigma

Recent research has argued that stigma in workplace settings stems from deep and automatic brain functions that have evolved over thousands of years. These evolutionary traits, common to all races and societies, may have helped to increase humanity's chances of survival in a group setting by 1) finding cooperative and valued individuals within the group and to avoid partners who appear of low value, 2) avoiding infectious diseases or dangerous conditions, and 3) preventing individual exploitation of shared or group resources (Brewis & Wutich, 2020; Link & Phelan, 2001; Phelan, Link & Dovido, 2008). To navigate the complexity of social life, stigma has evolved to assist rapid decision making by quickly identifying those who should be excluded from a cooperative group. Particularly, individual members will be stigmatised when they are perceived as a problematic or a low-value partner, carrying infectious diseases, and/or attempting to exploit shared group resources.

In groups, people are motivated to interact with each other and build relationships with cooperative partners who are seen to offer high value and avoid the ones who are seen to offer low value. A high value partner has the desired capability to achieve common goals, and is seen to have good intentions towards other group members (Boone & Buck, 2003). They should also be predictable and reliable in their behaviour. Injuries and illnesses may be perceived as signs of ineffectiveness and weakness, which may threaten group goals that are important for survival. Stigma is activated to short-cut the decision-making process and avoid potentially problematic partners within a group.

In a workplace setting, injured or ill workers may trigger this underlying process, resulting in stigma through being perceived as unreliable, dangerous/threatening, or incompetent. When a workplace injury or illness occurs, complex beliefs and stereotypes are activated to preserve productivity and minimise the risk of the worker compromising the organisation's position. Not only could an injured or ill worker be perceived as having low social exchange value, but they might also be perceived as a threat to the group (e.g., taking an unfair share of group resources).

Stigma as a way to exert control

Although stigma seems to have its roots in evolutionary processes, it can also emerge from people in powerful positions seeking to maintain the status quo (Long, 2018; Tyler & Slater, 2018). From this perspective, stigma can be understood as both an outcome of, and a supportive factor in maintaining power inequalities. These inequalities can be due to hierarchical influences such as organisational structure, or demographic characteristics such as the prevalence of injured/ill workers in relation to healthy/well workers. Within organisations, as in broader society, stigma occurs in conjunction with the social exclusion of weaker or less influential groups. These include injured and ill workers broadly, as well as groups who are less understood, such as workers with mental illness or injury, who are likely to experience additional stigmatisation. Through social influence and communication, negative stereotypes and ideologies can be established that legitimise the resulting discriminatory behaviour.

For instance, insurers and employers may strive to minimise costs wherever possible. In this way, a fundamental 'conflict of interest' or tension exists between the goals and objectives of workers, employers, and worker's compensation bodies. The workers' objectives are more likely to focus on achieving job security and stability, treatment, and long-term recovery, whereas employers are likely to focus on maintaining continuity of existing work output and minimisation of associated costs. Worker's compensation entities, although motivated to help employees recover and maintain wellbeing, are also under pressure to reduce expenditure and return workers to their jobs as quickly as possible. Stigma emerges in this power-charged situation and discourages injured or ill workers to access workers' compensation, through pressuring them to leave the organisation or otherwise suppress/hide their condition from others.

Discriminatory responses

Negative stereotypes may prompt discriminatory responses to exclude, oppress, and/or control the injured worker. These could include selective hiring, pressure to resign, or pressure to return to work early—some of which might prove unlawful under equal opportunity or anti-discrimination laws.

Stereotypes work to promote discriminatory responses by legitimising unfavourable treatment of other people. Stereotypes accentuate between-group differences and can even 'de-humanise' injured/ill workers, which results in a blunted guilt response and increased demonstration of discrimination by peers, managers, and even compensation case workers. Discrimination experienced by injured/ill workers can be categorised into three groupings:

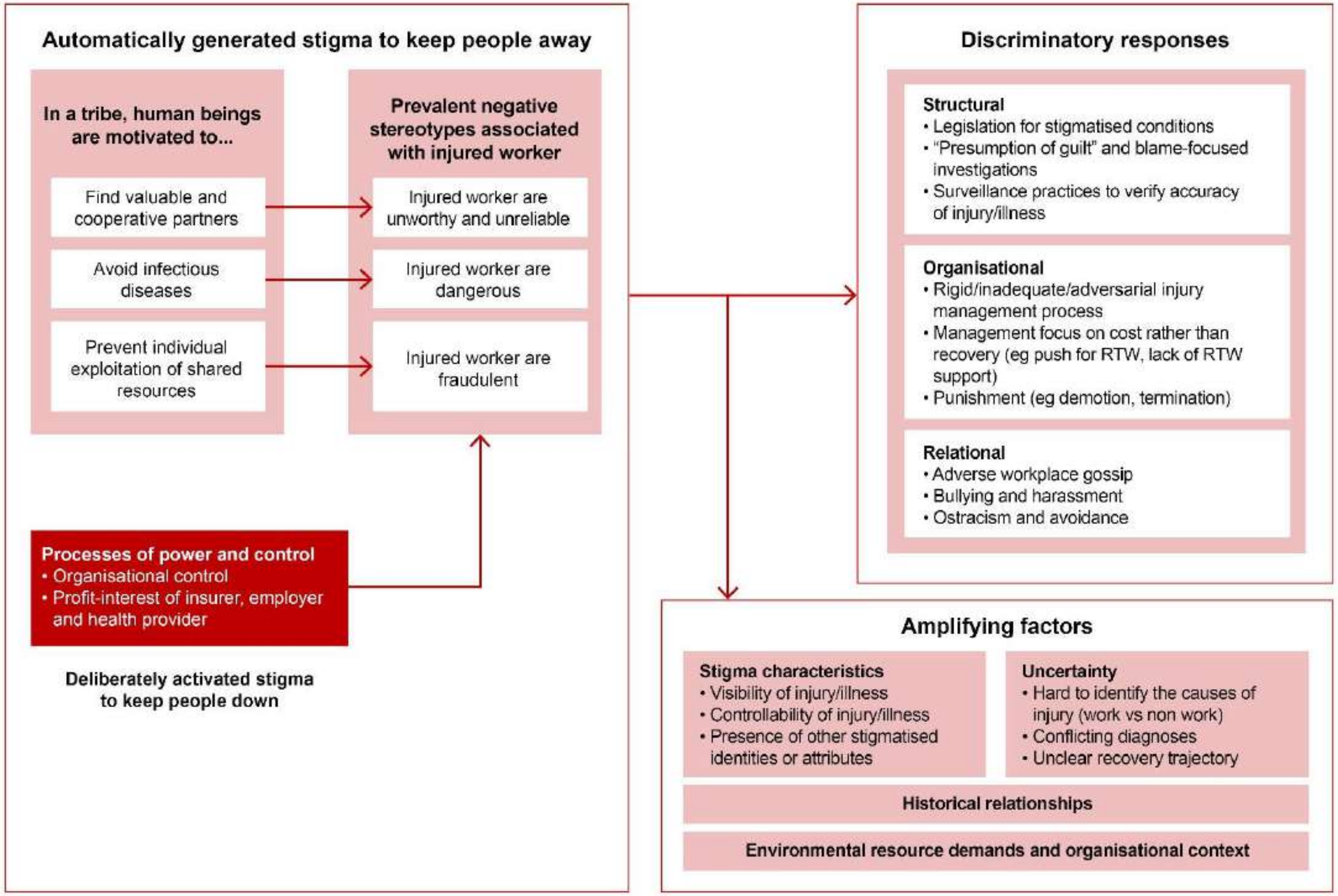
1. Structural discrimination: Societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and/or wellbeing of the injured/ill worker.
2. Organisational discrimination: Embedding stigma into organisational processes, structures and systems.
3. Relational discrimination: Prejudice and discriminatory behaviour experienced from leaders and/or co-workers around the injured/ill worker.

Each of these discriminatory actions is described in the sections that follow, and a visual overview is shown by Figure 2 overleaf.

Structural discrimination

As it relates to workplace injury and illness, various society-level and formalised aspects of stigma exist. The existence or absence of legislation for stigmatised conditions is one example, which can either facilitate existing stigmatised identities or conditions to be challenged, or reinforce them (Goldman, Gutek & Stein, 2006; Van Brakel, 2007). Another form of structural stigma is an implicit presumption of guilt and various investigation and surveillance processes (including the types of language used in workers' compensation claim systems) that convey a sense of wrongdoing or blame (Brijnath et al., 2014; Lippel, 2007), such as 'complex' or 'difficult' cases (Kirsch et al., 2012). For injured or ill workers, simply filing a worker's compensation claim or appealing a compensation board's decision about whether to accept or reject a claim can be enough to trigger experiences of self-stigma (Lippel, 2007). Self-stigma is the internalisation or endorsement of negative beliefs and stereotypes that an injured or ill worker perceives from their social environment and can be particularly harmful to recovery and overall wellbeing. Self-stigma occurs even in the absence of overt or demonstrated discrimination from others in the workplace.

Figure 3. Visual overview of the injury/illness stigma process.



Organisational discrimination

Organisations, like society in general, can embed discrimination and prejudice into their processes, structures, and systems in a variety of ways. This type of stigma is best considered as 'indirect' or implicit. For injured and ill workers, rigid, inflexible, or adversarial injury/illness management processes can force workers to exit the system early, minimise their use of facilities and treatment benefits, and even leave the organisation entirely (Côté et al., 2020; Robert-Yates, 2003). Lippel (2007) shared an example of a perverse disability management program in an organisation that included a manual with stigmatisation of an injured worker on the cover, which clearly insinuated the workers' perceived non-genuine intentions. Notwithstanding that in Australia, workers' compensation systems utilise medical evidence to process and verify claims, an injury management process that uses a medical model may be more prone to stigma because it emphasises deficiencies and adverse effects of the workers' condition rather than their positive capacities (Krupa et al., 2009; Kvalle et al., 2013). Management actions also convey a perception of support for wellbeing as well as the priority of injury management relative to financial or productivity-related goals (Robert-Yates, 2003). Finally, organisations can engage in direct discrimination through demotion or termination of injured and ill workers (Goldman et al., 2006; Stergiou-Kita et al., 2016).

Relational discrimination

Direct prejudice and discrimination can also originate from an injured worker's team members. Co-workers can engage in adverse workplace gossip due to stigmatisation of the injured or ill worker, spreading harmful rumours that seek to reinforce negative stereotypes (e.g., the worker is taking too long to return to the workplace so they must be fraudulent, or the worker receives 'special treatment' because of the injury; Kulik, Bainbridge & Cregan, 2008; Sager & James, 2005). Generally, ostracism and avoidance of stigmatised workers is a form of passive, but ultimately intensely negative discrimination, particularly given the fundamental human need to feel a sense of belonging (Hanisch et al., 2016). Finally, adverse direct behaviours such as bullying and harassment can also be experienced by injured/ill workers and may be a direct attempt by other group members to force a person to leave the organisation or otherwise keep them in a place of minimal power (Kirsh et al., 2012; Sager & James, 2005; Stergiou-Kita et al., 2016).

Stigma-amplifying factors

Amplifying factors are characteristics that increase the intensity of the stigmatisation of an injured/ill worker as experienced through harmful prejudice and discrimination.

In the next section, we describe four different groups of amplifying factors that can increase the intensity of perceived and experienced stigma in injury/illness-relevant settings. These groups of factors include the following:

1. Injury/illness characteristics: The visibility, controllability, and origin of the condition.
2. Worker-specific characteristics: Socio-demographic characteristics.
3. Organisational characteristics: Business size and organisational culture.
4. Uncertainty: The level of uncertainty within the injury management process and recovery/return to work.

Consequences of these amplifying factors can include 1) increasing the visibility or salience of the perceived negative characteristics/attributes, 2) further embedding and reinforcement of negative stereotypes, and 3) intensifying the likelihood and severity of prejudice and discrimination.

Injury/illness characteristics

Characteristics of the injury or illness itself can also affect the experience of stigma. In this section we discuss three relevant characteristics: visibility, controllability, and origin.

Visibility of the condition

Visibility is a highly influential factor because it means a worker can hide or choose to mask their injury or illness from others (Goldman et al., 2006; Kirsh et al., 2012; Summers et al., 2018). Although the condition may be hidden from view, importantly, the person may still suffer psychologically due to possessing a 'discreditable' identity—in other words, there is a potential for others to discover the condition and engage in stigma (Kirsh et al., 2012). Conditions or injuries without visible signs or symptom increase stigma by intensifying stereotypes related to malingering and workers taking advantage of compensation systems (Lippel, 2007; Lippel, 2012). Some forms of mental health conditions, such as depression and anxiety, and physical conditions such as back pain could be masked by individuals who can function effectively at work and in life, which in turn may delay seeking help and promote self-stigmatisation.

Controllability of the condition

The controllability of the injury or illness (i.e., whether a health condition is manageable by the worker) is another important factor because it determines the intensity of the impact on everyday activities in the workplace (Summers et al., 2018). A more controllable or manageable condition is less likely to cause disruption to relationships or working patterns, and so the stigma is reduced. Also, conditions that have variable symptoms, such as some chronic illnesses (Beatty, 2018), are likely to cue stereotypes related to reliability and productivity of injured or ill workers. Stereotypes around legitimacy of the condition may also be triggered if symptoms are variable.

Origin of the condition

Workers with chronic illnesses such as cancer may be treated with stigma due to the perceived cause of their ailment (Beatty, 2018). For instance, lung cancer due to a history of smoking may evoke harsher stigma from colleagues. This stigma derives from blame against the injured/ill worker for creating the condition through lifestyle or workplace behaviour choices (i.e., the worker consciously chose to engage in the at-risk behaviour that resulted in an injury/illness). On the other hand, types of hereditary cancers may be <u>less</u> prone to stigma in the workplace due to origin-related perceptions and attributions around the workers' responsibility for their condition.

Worker-specific characteristics

For workers with low social status, stigma can be debilitating because it is easier for the powerful group to exert dominance and influence over them, and legitimise negative stereotypes (Goldman et al., 2006; Kirsh et al., 2012; Van Laar et al., 2019). Workers with multiple stigmatised identities can experience 'cumulative stigma', which dramatically intensifies the potential for prejudice and discrimination in the workplace (Brijnath et al., 2014; Kirsh et al., 2012). For example, an injured or ill worker may not only experience a stigmatised condition (e.g., mental health concern) but also be part of a minority ethnic group and an age demographic. Importantly, workplace-related injury/illness stigma does not have to be directly experienced to influence the wellbeing and disclosure/claiming/recovery-related behaviour of the worker. Self-stigma occurs when the individual is acutely aware of their own stigmatised condition and adopt the corresponding negative stereotypes as a part of their own internalised identity.

Organisational characteristics

Research on organisational characteristics and injury/illness stigma is in its infancy, however, two characteristics appear to be important:

1. Business size.
2. Organisational culture.

Business size

Business size may be influential in the experience of stigma by injured/ill workers. The context of the organisation is influential because different sizes and types of organisations may be prone (or resistant) to stigma due to underlying cultural assumptions (Clair et al., 2016). Eakin et al. (2003) argued that small business employers can feel a self-imposed obligation or 'moral imperative' to police the legitimacy of injured/ill workers' compensation claims to avoid increased insurance premiums. Others such as Kirsch and colleagues (2012) proposed that small businesses may focus more on cost minimisation than larger businesses due to the impact of labour hire and delayed or reduced production. Regardless, small businesses are likely to be more variable in the experience of stigma than larger businesses. Large employers are more likely to have external accountability (e.g., shareholders, executive boards) and greater access to resources that can be used to support and help injured/ill workers, hence, variability in practices and stigma experiences is likely to be lower among this group.

Organisational culture

According to Thompson and Grandy (2018), organisational culture may either intensify or mitigate stigma. This differing outcome occurs because stigmas are collectively defined within cultures at the societal level, which are then interpreted within the frame or lens of the dominant organisational culture (Clair et al., 2005). Organisations with cultural assumptions pertaining to masculinity and capability (such as law enforcement and military) are more prone to cultivating the negative stereotypes associated with weakness and malingering that underlie stigma, requiring them to implement practices such as mandatory mental health checks to combat reduced help-seeking behaviours (Price, 2017). In a hierarchical and operationally demanding organisation, a visible physical injury may be interpreted as a sign of heroic performance; therefore, stigma may be less likely to occur because the heroism legitimises the injury. Culpability rests with the organisation or the external environment rather than being a moral shortcoming of the injured worker. In the same organisation, a mental health condition acquired through stressful interactions with colleagues may be interpreted as a sign of inherent weakness (i.e., the employee 'can't handle' the demands), or otherwise questioned around its legitimacy (i.e., the employee is 'milking the system').

Uncertainty

Uncertainty is a contextual factor that may affect the intensity and likelihood of injury/illness-related stigma. Within the injury and illness context, there are three main sources of uncertainty. The first relates to the diagnosis. Workers can be misdiagnosed, creating confusion and disbelief, or different medical practitioners can have conflicting views about the nature of the injury/illness (Bjorklund, 1998). The case may also be questioned around its authenticity, particularly in relation to the cause of the injury—such as whether it is work-related or not (Tarasuk & Eakin, 1995). And finally, the prognosis or anticipated recovery of the injured/ill worker can be unclear or change suddenly part-way through the process (Côté et al., 2020). To cope with this uncertainty, stakeholders within the injury management process may find themselves stigmatising others or experiencing stigma themselves (Poteat, German & Kerrigan, 2013). For example, if an injured/ill worker takes longer to recover than average, they may find themselves labelled as a 'malingerer'.

Outcomes of stigma

In this section, we outline the consequences of stigmatisation on injured workers, which is best considered as a process starting with awareness of the relevant negative labels/stereotypes associated with specific injury/illness conditions, followed by the psychological experience of stigma, and lastly, the behavioural expression or manifestation of stigma across the three phases of a workplace injury/illness. The model suggests that stigma has significant potential consequences for workers' willingness to report illness or injury, engage in workers' compensation claims processes, and their ability to transition effectively back to work after an incident. Figure 4 overleaf shows a visual overview of this model. For example, after the psychological phase, a worker may engage in behaviours during different stages of the claims process. A worker who is aware of negative stereotypes about their condition may internalise stigma through feelings of shame, preventing them from disclosing their injury.

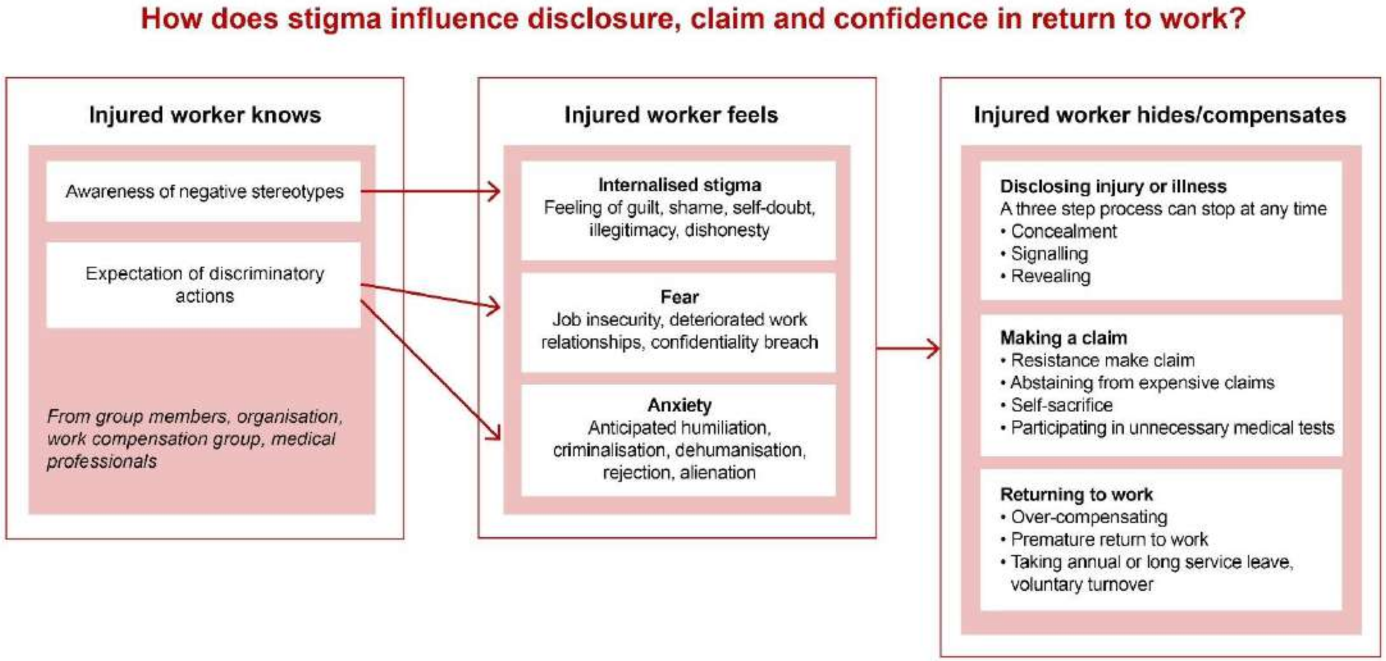
Awareness of negative labels/stereotypes

People who are labelled with stigmatising conditions become aware of their situation over time. When people perceive a stigmatised attribute or label has been ascribed to them, and internalise it over time, it can leave lasting changes on their neural and psychological makeup. Following the activation of regions in the brain associated with pain, deep fear, and behaviours such as withdrawal and avoidance are automatically prompted. An injured or ill worker often expects to receive discrimination from others, or receive actual discrimination (Vornholt et al., 2013). These actions confirm the stigmatised identity for the injured or ill worker, which does not have to be internalised for negative outcomes to result.

The feelings of stigma

The experience of stigma is an extremely stressful and psychologically damaging experience. This experience is characterised by three experiences: self-stigma, fear, and anxiety. Internalised or self-stigma results in feelings such as guilt, shame, and self-doubt (Brijnath et al., 2014; Lippel, 2007). These feelings result in the injured or ill worker questioning their own integrity and legitimacy, and they can feel dishonest in the situation.

Figure 4. Visual overview of the effects and impact of injury/illness stigma on workers.



The primary feeling that injured or ill workers have when choosing whether to disclose is fear. Fear can be experienced in several ways, and most commonly include fear of job insecurity, fear that confidentiality will be broken, and fear that workplace relationships will be adversely impacted.

On return to work, the salience of co-worker or employer social withdrawal, avoidance, and/or ostracism means that injured or ill workers are likely to experience strong feelings of humiliation, abandonment, and alienation. There may also be mutual distrust regarding the relationships between the worker and their co-workers or team.

Behavioural outcomes of stigma

Outcomes of stigma can be divided by the phases or stages of the injury management process (i.e., disclosing, making a claim, and returning to work).

Disclosing an injury or illness

Together, these strong emotions create a tendency to avoid or withdraw from disclosure, either to the employer or to significant others such as family or friends. Failing to tell significant others can be a reaction to anticipated 'courtesy stigma' whereby the family member will be associated negatively with the stigmatised worker. Broadly, disclosure can be modelled as a three-step process that can stop at any time, resulting in the injury/illness being concealed, with long-term recovery implications. Concealment is the active and intentional process of masking an injury or illness, such as 'faking good' or hiding pain and discomfort at work. Signalling is a partial decision to disclose, whereby the injured/ill worker shows small signs that they need help. Finally, revealing is the final step whereby an injured/ill worker engages in full disclosure, risking stigmatisation from the group.

Making a claim

Injured/ill workers can avoid engaging in the claims system entirely or abstain from various expense claims to ensure costs are kept low (and impacting their treatment and recovery). Feeling disempowered, workers also engage in tests or assessments that they otherwise would not agree to, calling into question their level of consent for such procedures. Self-sacrifice can also occur, where the worker purposefully downplays or minimises the severity of their condition, or otherwise does not engage in treatment and/or receive benefits that they are entitled to.

Returning to work

At the time of returning to work, the worker can engage in over-compensating task behaviours, performing duties that could be detrimental to their long-term recovery out of eagerness to challenge the negative stereotype and 'prove' to colleagues that they are capable. Similarly, the worker could return prematurely before recovery is completed. Alternatively, if the stigma experience is too intense, the worker may elect to take additional annual leave or long-service leave to avoid the negative work environment.

Conclusions

Recognising the limitations of existing stigma literature, we clarified the definition of stigma, positioning it as an evolved function that served a distinct survival purpose for our ancestors living in social groups. Three fundamental motives cause stigma in the workplace: finding valuable and cooperative partners, avoiding infectious diseases, and preventing exploitation of shared resources.

We also considered the power plays that groups can exert over injured or ill workers to intentionally maintain the status quo. Power plays derive from a conflict of interest or tension between the needs of the injured or ill worker, and the desire of stakeholders to maintain control (e.g., over spiralling costs, organisational competitiveness, or productivity).

Finally, we developed two key models to visualise the processes and elements involved in workplace-related stigma toward injured and ill workers. By understanding more about how stigma originates and operates, organisations and individuals can challenge automatic labels and stereotypes. They can also implement changes to existing structures and practices that facilitate more effective injury disclosure, claims activities, and optimal return to work.

Chapter 3: The evidence for workplace protective factors and specific interventions

In this chapter we provide synthesised evidence for ways to reduce stigma in workplace settings. Table 1 below summarises the evidence collated during this project.

Table 1. Summary of evidence points for each protective factor.

Protective factors	Type of evidence (the kind of data)	Domain of evidence	Academic consultation*	Industry consultation*
Inclusive organisational culture	Conceptual, correlational studies	Injury stigma, LGBTI+ stigma, diversity and inclusion	+	++
Supportive leadership	Intervention studies, qualitative studies	Injury stigma, diversity and inclusion	+	++
Health literacy programs	Intervention studies	Mental health stigma, sports	++	+
Formal policies and procedures	Correlational studies	Welfare stigma, and other work-related stigma	++	+
Peer support group	Intervention studies, qualitative studies	Self-stigma, Injury stigma, LGBTI+ stigma, diversity and inclusion, sports	+	++
Psychological support	Intervention studies	Self-stigma	+	+

Each of these protective factors and organisational action areas are explored further below.

Inclusive organisational culture

According to the competing-values framework (Cameron & Quinn, 2011), an inclusive culture is characterised by the following features:

- Leaders are mentors.
- The organisation has a strong sense of community and 'togetherness'.
- There is an emphasis on human resources practices that foster training and development.
- Performance is measured by meeting clients' needs and supporting/caring for employees.

- Teamwork and cooperation are encouraged.

Related to stigma, community-based beliefs (i.e., where the organisational culture supports employee wellbeing and supportive relationships) are associated with workers' decisions to disclose a stigmatised condition (Lyons et al., 2017). Cultures with a greater level of perceived support and benevolence towards employees tend to encourage disclosure of injury and illness. Similarly, a study of law enforcement officers in the USA showed that perceptions of a supportive organisational culture was significantly related to willingness to use stress intervention services (Tucker, 2015). In a military setting, Britt and colleagues (2019) found that perceptions of support for mental health were associated with lower perceived stigma as well as higher help-seeking behaviours. On the contrary, an organisational culture that preferences masculinity, competitiveness, aggression, and stoicism can amplify perceptions of mental-health stigma (Bikos, 2020). Overall, a culture of inclusiveness and support appears to be instrumental in reducing the effects and likelihood of stigma.

Instituting an organisational culture of inclusiveness and support requires a multi-pronged approach (Kulik et al., 2008). Organisations can institute recruitment and selection practices that emphasise candidates with egalitarian attitudes. Further, organisations can implement diversity management initiatives that ensure equal opportunity for candidates with pre-existing injuries and illnesses that may be stigmatised. These actions increase contact and exposure to people with injuries and illnesses among the workforce. Training and development activities that encourage contact with people who have a lived experience of a stigmatised condition can also contribute to a supportive culture. Targeting and eliminating workplace gossip or informal and unprofessional communication through strong cultural norms is another way that stigma could be combatted.

Supportive leadership

We identified five mechanisms through which leaders might mitigate the negative impact of stigma:

1. Use constructive/positive leadership styles to affect worker's experience and perceptions of stigma.
2. Provide advice and support to someone in distress.
3. Build trusting relationships between supervisors and workers to reduce barriers to disclosure.
4. Refer injured/ill workers to adequate resources and support and encourage access.

5. Create a supportive organisational culture.

Explorations of leaders' role in combatting workplace stigma are in their infancy, but some research has been done to date. A program of research by Dimoff and colleagues concerning a 'mental health awareness training' for supervisors and managers is a prime example of this approach (e.g., Dimoff & Kelloway, 2019). Leaders can reduce the impact of stigma directly through supportive behaviours directed towards ill or injured employees. Specifically, leaders can be trained in 'supportive conversation' skills that enable deep and meaningful relationships (i.e., trustful), reducing perceived barriers to disclosure (Ellis et al., 2017). Furthermore, leaders can provide direct assistance to workers through applying basic mental health first aid and referring the worker to internal or external support services. In essence, leaders can facilitate help-seeking and encourage engagement with workers' compensation systems and injury management processes. For example, in a military setting, leadership styles were found to predict perceived stigma and anticipated barriers to seeking mental health treatment among non-commissioned army officers (Britt et al., 2019).

Senior leaders shape the organisation's culture (Shann et al., 2019) through role-modelling, rewarding, and sanctioning workers' behaviours. They espouse values and priorities, leaders in organisations establish strong norms or 'implicit rules' that influence how workers think and act. Essentially, senior leaders shape the core beliefs and assumptions held and shared across employees within an organisation (Schein, 2010).

Health literacy programs

To date, the most researched stigma reduction intervention is general education or health literacy programs. These programs typically cover topics such as providing information about the nature, causes, symptoms, and recovery/treatment of injuries and illnesses. For example, a typical psychoeducation-based program that concentrates on mental health conditions is designed to encourage help-giving and referral to people with similar conditions in the workplace until professional support can be obtained (Kitchener & Jorm, 2008). Example program content includes symptoms and risk factors of common mental health problems, skills to provide 'mental health first aid' such as listening, reassuring, and encouraging professional and self-help strategies, and some perspective-taking activities and narratives from people with lived experiences. These interventions are typically in-depth, lasting at least 7-8 hours and in the case of mental health first aid, sometimes up to 12 hours (Kitchener & Jorm, 2008).

Formal policies and procedures

Beyond complying with equal opportunity and anti-discrimination law, policies that promote inclusivity and equality are an essential foundation for reducing stigma in the workplace. Further, policies can be developed and implemented by businesses of all sizes and are an opportunity for management to set expectations for how people will conduct themselves within the organisation. Workers have a duty to take reasonable care of their own health and safety in the workplace, and the health and safety of others who may be affected by what they do or do not do. Workers must comply with any reasonable instructions, policies and procedures given by their employer at the workplace, including policies and procedures to prevent poor workplace behaviours. From the diversity and inclusion literature (e.g., Webster et al., 2018), formal policies surrounding equality of different sociocultural/demographic groups (e.g., LBGTI+, racial minorities) can be instrumental in guiding injury management. For instance, diversity and inclusion policies can be developed that align injury management processes (e.g., complaints handling, career mobility and retraining, transitioning out of the organisation, employee-employer collaboration) with principles that support disclosure of injuries/illnesses, claims, and returning to work. Importantly, staff and those with lived experience, as well as peak representative bodies for injuries or illness types should be invited to contribute to these policies.

Peer support groups

Peer support groups can be a powerful source of assistance and protection for workers who are injured or ill in the workplace. Such groups provide an outlet for injured/ill workers to share either perceived or experienced stigma, ‘reality check’ internalised stigma experiences, and gain social support to facilitate the claims process, recovery and return to work. For return to work, supportive peers can ease the transition process and help to reintegrate injured/ill workers back into the team. Peer support groups can also assist injured/ill workers by acting as advocates and representatives to management or external parties such as the workers’ compensation provider.

Psychological support services

Direct psychological support services are a secondary intervention that can assist workers to reduce or eliminate the negative effects of stigma. For instance, counselling can be used to help injured/ill workers process experiences of stigma and develop helpful coping and responding strategies. Where psychological support may be particularly impactful is to help workers manage self-stigma. Through techniques such as mindfulness and cognitive behavioural therapy, counsellors and psychologists can help workers to not only be self-aware of negative thinking and self-stereotyping, but actively challenge such adverse beliefs and prevent self-stigma. These services can also mitigate the development of secondary psychological injuries that can result from experiences or perceptions of stigma, preventing a flow-on effect to recovery and return to work.

Stigma-reduction practitioner survey

As part of our consultation process, 150 Australian HR and WHS practitioners were invited to participate in a short survey. This survey included lines of enquiry such as: 1) whether organisations had conducted, were currently conducting, planned to conduct, or had not conducted stigma reduction initiatives and which ones they were implementing, 2) the effectiveness of these initiatives, and 3) the prevalence of injury/illness-related stigma within this sample of organisations.

Participants were recruited by an Australian specialist online survey panel company. Participants received a $10-15 reward for successfully completing the survey. A Qualtrics survey was used to collect the information (with data stored in Sydney, Australia).

Key findings from the practitioner survey

Several important findings emerged from the survey and are listed below.

39% of practitioners anticipated that stigma towards injured and ill workers exists in their organisations and agreed that there may be negative repercussions for workers who disclose an injury or illness at work (notably, this figure is similar to the NRTW survey result).

- Most large businesses (150 employees or more) reported engaging in one or more stigma reduction initiatives, but this result was reversed for small business.
- Further to the previous finding, small business practitioners were significantly less likely to report high levels of stigma than larger businesses, and generally rated help-seeking and supervisor support for injury/illness more favourably.
- Over two-thirds of practitioners stated that stigma-reduction initiatives (e.g., psychoeducation, leadership development, peer support) conducted in their organisations were successful.
- Although 24% of practitioners reported no barriers to implementing stigma-reduction initiatives, others indicated that the pandemic and environmental conditions such as market fluctuations, lack of management support, and

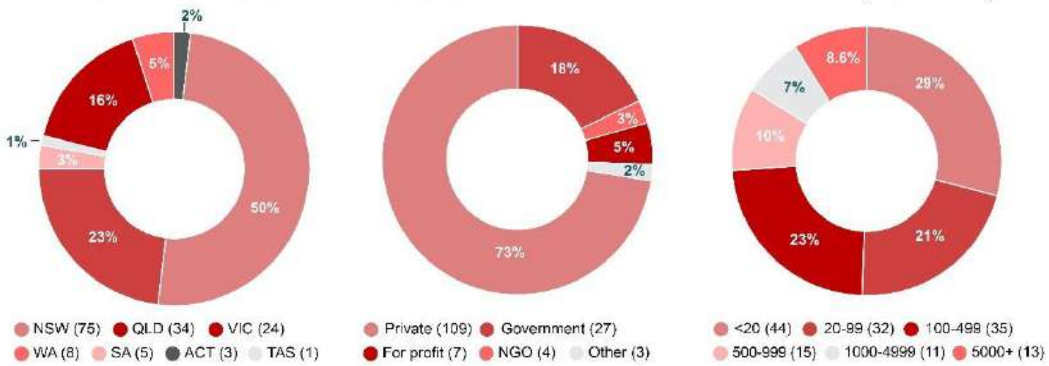
inadequate internal capability were experienced barriers that had to be overcome.

- Practitioners preferred to receive the following help and support from insurers and WHS regulators: 1) simple to understand guidance and fact sheets about stigma, 2) injury management capability training for leaders, 3) help to influence senior management to take action on stigma and health/wellbeing, and 4) greater awareness of existing programs already available through insurers and regulators.

Figure 5 overleaf summarises additional findings from the stigma reduction practitioner survey.

Figure 5. Results of stigma-reduction practitioner survey.

150 Australian HR and WHS professionals with oversight/involvement in stigma reduction initiatives



Findings of note

Small businesses (**<20 employees**) were significantly less likely than all other business sizes to have conducted or planned stigma reduction initiatives (**77%** of small businesses said they have not considered stigma reduction compared with only **29%** of larger businesses).

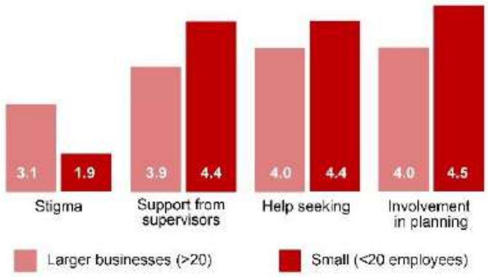
57% (85) of respondents stated that their organisation had conducted or was conducting stigma reduction initiatives.

Empowerment of employees with lived experience of stigma was the initiative most likely to exceed expectations (**24%** of respondents who were conducting or had conducted initiatives stated that this type of program exceeded their objectives).

Organisations (**25%**, 21 of them) were least likely to measure the success of peer support programs at reducing stigma.

Government organisations were perceived as slightly less likely than private organisations to involve injured/ill workers directly in injury management planning.

- **Government 'involvement' average =** 4.0 / 5.0 (5.0 = strongly agree, 1.0 = strongly disagree)
- **Private 'involvement' average =** 4.2 / 5.0 (5.0 = strongly agree, 1.0 = strongly disagree)
- Compared to larger businesses, small businesses were perceived as significantly less likely than larger businesses to have injury/illness stigma, and more likely to offer proactive support to injured/ill workers, workers were more likely to seek help if injured or ill, and be more involved in injury management planning.



What support would industry like from insurers and regulators to reduce stigma?

- Simple and easily understood guidance materials to help build capability and awareness about stigma.
- Free/low cost and low resource intensive training programs for leaders to support injured/ill workers to make a claim and return to work.
- Tools and resources to influence/persuade senior managers to take notice of stigma and improve injury management capabilities in the organisation.
- Greater awareness of insurers' support programs and initiatives/incentives to help manage injury/illness cases.

What barriers have prevented organisations from conducting stigma reduction programs?

- **24%** of organisations reported no barriers to implementing stigma reduction initiatives.
- **45%** reported that the impact of the external situation, such as COVID19, had impacted their ability to implement initiatives.
- **25%** reported that they lack senior management support for stigma reduction initiatives at this time.
- **21%** said that the organisation lacks suitably skilled internal resources to develop and implement initiatives.

Chapter 4: Recommendations

Integration

The recommendations framework combines the most recent national and international research with the expert opinions and experiences of industry leaders and researchers obtained through consultation during this project. The objective is to support the development of evidence-based recommendations to reduce stigma towards injured/ill workers through inclusive organisational cultures and supportive leadership capabilities.

The framework directly targets employers (senior management and business owners) and is based on the principle of integration, which is explained further below.

Why integrate?

Integration of stigma within existing health and wellbeing initiatives creates efficiencies and synergies that would otherwise be unrealised if stigma were decoupled and treated as a separate area of focus. Regarding efficiency, mental health and general wellbeing initiatives can be extended to incorporate stigma topics and interventions. For instance, a general mental health literacy program can be expanded to include content related to stigma and its impact on workers through presentations by persons with lived experience. ‘

Synergistically, combining concepts of stigma with other wellbeing initiatives opens opportunities for discussion about various conditions and their effects on others. Further, expanding health and wellbeing initiatives across multiple domains with stigma-related concepts (i.e., addressing discrimination in HR policies, providing training to leaders in supportive conversations and increasing stigma literacy, and stimulating team level discussions about workplace civility with consideration of stigma) can contribute to workforce trust, organisational commitment, to health, safety, and wellbeing.

The risks of decoupling stigma from existing activities are increased costs, reduced training, and confusion among workers regarding how stigma fits within organisations’ broader health and wellbeing initiatives.

How can integration be done?

By incorporating stigma within existing education and organisational development activities, employers can leverage benefits beyond workers’ compensation and injury management. Integration removes barriers to the establishment of a supportive and inclusive workplace.

An integrated intervention is likely to include several components. For instance, the intervention could:

1. Review existing HR policies to identify potential processes that may create discrimination such as complaints or performance management processes. Based on the review consider implementation of broader diversity and inclusion policies.
2. Provide online training in mental health literacy that includes aspects of stigma awareness and contact with persons who have lived experience.
3. Offer role-specific and skills-based training for key people in the organisation (e.g., a 'peer support officer' who is skilled up to provide advice and referrals to injured/ill workers).
4. Develop or integrate existing information resources and guides on workers' compensation process to educate employees about sources and experiences of stigma.
5. Develop holistic health and wellbeing communications campaigns that incorporate stigma as a key element or component to developing a supportive and inclusive workplace.

Overall, these interventions are likely to be more effective at reducing stigma when they target organisational (e.g., design of injury management processes, presence of a return-to-work coordinator), team (e.g., supportive leadership), and individual (e.g., knowledge, attitudes) factors (MacEachen et al., 2006), and broadly encompass the concept of health and wellbeing.

Recommendations

Recommendation 1 – Build leadership capability

Organisations should improve leaders' health and well-being literacy through awareness, training, and guidance material to reduce stigma.

Organisations should develop leadership capabilities to reduce stigma within workplaces through education and awareness, implementation of peer support services, intervening in bullying and discriminatory behaviour and effective communication with injured workers. Leverage existing leadership development activities to support a mentally healthy workplace that is free from stigma. Practical suggestions to build leadership capability are:

- Encourage leaders to pay close attention to and intervene in bullying and discriminatory behaviour before injury/illness occurs.
- Develop leaders' awareness of injury management processes, requirements, and obligations.
- Foster team communication about health and wellbeing topics, including topics such as workplace stigma and encourage the uptake of flexible work practices.
- Encourage leaders to check-in with injured and ill workers throughout and following disclosure, claiming, recovery, and rehabilitation/return to work.
- Develop an understanding of the supportive roles played by an injured/ill worker's peers, family members and friends, and involve them in discussions about the worker's treatment and return to work, where appropriate.
- Ensure there are clear grievance and complaints procedures in place, with information about these procedures available to all workers so that if an injury management claims process is of poor quality, an injured/ill worker has recourse to drive improvements.

Building leaders’ health and wellbeing literacy will reduce stigma and assist with creating a proactive and supportive environment for injured workers.

Recommendation 2 – Implement formal policies and procedures to reduce stigma

Organisations should consider implementation of formal policies and procedures to embed practices that aim to reduce stigma.

To reduce stigmatisation of injured or ill workers, organisations should expand upon existing health and wellbeing to normalise disclosure of injury and illness within the workplace. This may include developing policies that encourage flexible working arrangements and appropriate alternatives to line management for disclosure of injury/illnesses (e.g., in bullying scenarios, ensure there is an alternative pathway to reporting apart from via the direct supervisor).

Suggestions on practical ways to implement policies and procedures that reduce stigma are:

- Develop an internal policy on injury/illness disclosure that states workers must not be discriminated against and that their confidentiality is assured where possible.
- Utilise written policies on diversity and inclusion to set expectations around how injuries and illnesses will be handled in the workplace. Integrate these policies into workforce induction processes.
- Develop a policy on flexible work arrangements to cater for different conditions that an injured/ill worker may experience and draw on this policy when designing and implementing workplace accommodations.
- Ensure procedural fairness can be maintained during performance management by considering the timing of performance management discussions and ensuring the injury/illness case is not considered separately to any performance issues.
- Include health and wellbeing criteria into performance and promotion discussions (e.g., reductions in team stigma, improvements in employee speaking up behaviour and incident reporting).
- Create feasible and appropriate alternatives to line management for disclosure of injury/illnesses (e.g., in bullying scenarios, ensure there is an alternative pathway to reporting apart from via the direct supervisor).
- Engage with family members/friends where appropriate and provide them with regular information about the claims process, injury management at the organisation, and reassurance.
- Create capability in the organisation for agile workforce planning and alternative resourcing to mitigate the impact of reduced productivity when an injured/ill worker is absent or at reduced capacity.

Extension of formal policies will reduce perceived bias, discrimination and unfairness for injured workers and assist with recovery and return to work.

Recommendation 3 – Change cultural attitudes towards injured workers

Organisations should consider incorporating stigma awareness and prevention strategies through existing policies and procedures.

Organisations should facilitate the development of a supportive and inclusive workplace culture. This includes incorporating best practice approaches into health and wellbeing interventions, create a mentally healthy environment by extending existing training and development to include stigma concepts, and engage in extensive and ongoing workforce consultation to monitor the prevalence and impact of stigma. Some practical suggestions for creating cultural change within organisations are:

- Leverage online training modules to trigger changes in stigma-related attitudes and beliefs among workers.
- Ensure workforce health and wellbeing training includes storytelling, role-plays, and active discussion to stimulate change in negative attitudes, beliefs, and stereotypes that underpin stigma.
- Provide workers with opportunities to hear the stories of injured/ill workers and their journeys through disclosure, claiming, and recovery, who may be sourced either internally to the organisation (if appropriate) or externally.
- Consult with and involve persons with lived experience of injury and illness within the design phase of health and wellbeing programs/initiatives, and to help with the review of injury management systems and processes.
- Provide training to employees in how to make an injury/illness disclosure, focussing on who to talk to, how to have the conversation, and the benefits of speaking up for long-term treatment effectiveness and recovery.
- Support teams to proactively prepare for and reintegrate the injured/ill worker on return to the workplace (e.g., discussing suitable accommodations, workload allocation and planning, social support mechanisms).

Integration of awareness and prevention strategies for stigma reduction into existing health and wellbeing initiatives will assist with changing organisational cultures.

Recommendation 4 – Monitor the effectiveness of stigma reduction strategies

Organisations should consider the development of measurement frameworks to monitor the prevalence of stigma within the organisation and the effectiveness of stigma reduction strategies.

To monitor the effectiveness of stigma reduction strategies, organisations should conduct regular employee wellbeing consultation processes to identify factors impacting the effectiveness of stigma reduction. The following suggestions are made for creating measurement effective measurement frameworks:

- Conduct a regular (i.e., annual) employee wellbeing consultation process (such as a survey or focus group/interview process) to identify factors like senior management support and commitment to health and wellbeing, perceptions of injury/illness stigma, clarity and understanding of injury management processes, and willingness to disclose and engage in help-seeking behaviour.
- Expand health and wellbeing monitoring and evaluation to include injury management process quality and stigma-relevant concepts (e.g., perceived negative repercussions for speaking up about an injury at work).

Measuring the effectiveness of stigma reduction strategies will assist organisations to create and maintain cultures that support injured workers.'

Recommendation 5 – Raise awareness of the impact of stigma in the workplace

Policy makers, Insurers and Workers Compensation Authorities should consider the development of awareness campaigns and guidance material for employers on the adverse impact of stigma in the workplace.

Policy makers, Insurers and Workers Compensation Authorities should work more collaboratively to create or leverage existing communications materials or training modules which reduce stigma in workplaces. There are many options for raising awareness of the adverse impact of stigma in the workplace, the following are some ways that this could be undertaken.

- Expand mental health/wellbeing and general stigma reduction programs and campaigns to include consideration of the workplace injury/illness context.
- Develop a fact sheet regarding workplace injury/illness stigma for employers and workers that highlights the nature of stigma, its impact/effects, and what can be done to mitigate it.
- Recognition of employers who are successful in reducing or eliminating stigma towards injured/ill workers, through existing regulator/insurer-sponsored awards (e.g., calling attention to the stigma reduction outcomes of a broader mental health program). Existing jurisdiction-level reward programs have been effective at identifying and promoting mental health and wellbeing capabilities across employers.

- Develop a list or catalogue of existing stigma-relevant resources available through the various jurisdictions and promote this list to employers and workers through unions, associations, and other communication networks.
- When developing new mental health and wellbeing guidance materials, consider engaging directly with workers who have lived experience of the claims process to help design these resources (e.g., through relevant peak bodies and disability organisations).
- Develop guidance for family members/ friends regarding the claims process to better support the injured worker.
- Facilitate collaboration and networking (e.g., resource pooling, knowledge sharing) between businesses through industry mental health and wellbeing events and forums/groups.

Workers' compensation authorities could also assist organisations regular communication between organisation and health care/treatment providers involved in the injured/ill worker's case. There is also an opportunity to draw on persons with lived experience to help design campaigns and resources around health and wellbeing and facilitate employer-to-employer interactions that create capability through peer networking. Guidance for employer communication and engagement is contained in Attachment A of this report.

Recommendation 6 – Undertake further research on behaviours impacting workplace stigma

Policy makers, Insurers and Workers Compensation Authorities should consider undertaking further research to better understand behaviours relating to workplace injury/illness to extend research done on attitudes and intentions.

Policy makers, Insurers and Workers Compensation Authorities should conduct a more in-depth investigation of how to change discriminatory behaviours relating to workplace injury/illness, to extend research done on attitudes and intentions. Consider sponsoring additional focussed research to develop a business case for building supportive and inclusive workplaces that are stigma-free. Similar work done in Australia regarding the costs of poor mental health have generated significant attention and investment in preventative actions, and this work could be expanded to stigma and supportive workplace environments (i.e., mentally healthy workplaces).

Recommendation 7 – Improve data collection of the impact of stigma

Policy makers, Insurers and Workers Compensation Authorities should consider improving data collection of the impact of stigma on injured workers through existing national surveys to assist employers, workers' compensation and work health and safety regulators with understanding the impact of existing policies and changes over time.

Chapter 5 – Conclusions

Stigma is a difficult challenge for workers' compensation insurers, employers, and injured/ill workers themselves to overcome. Data from the NRTW Survey highlight that a significant proportion of injured/ill workers in Australia perceive they are likely to experience stigma associated with their condition, which can affect the likelihood of disclosure, the efficiency of the claims process, and recovery and return to work outcomes.

Fortunately, evidence suggests that stigma can be reduced. Health and wellbeing literacy programs and contact exposure with persons who have current or lived experience of injury/illness have been extensively studied and shown to be effective, at least in terms of challenging existing attitudes and beliefs. Other conceptual and descriptive research has opened new lines of intervention for future researchers to explore.

Our research strongly suggests that stigma can be reduced through integration of existing health and wellbeing initiatives, education, and leadership development. An integrated approach can generate efficiencies and synergies that would not be realised if stigma was targeted in isolation.

We acknowledge that many resources and tools exist in workers' compensation insurers websites and print materials, however there is opportunities for improvement. Some jurisdictions exhibit structural stigma through heavily text-based websites that make information difficult to find and lack practical tips and tools that stakeholders can use during injury management and workers' compensation processes. Others offer user-friendly experiences that highlight key pieces of information through video and offer comprehensive 'manuals' that describe in depth the claims process. Some jurisdictions offer a suite of support programs that are appropriate for both employers and employees. Rather than replicating and reinventing these resources and programs jurisdiction-by-jurisdiction, potentially leading to some signals of structural stigma and inequity depending on the location of the injured/ill worker, we encourage policy makers, insurers, and workers' compensation authorities to collaborate more openly and pool resources for the benefit of reducing stigma and improving recovery and return to work outcomes.

There are three main areas we believe will lead to effective outcomes for stigma reduction into the future. Policy makers, insurers and workers' compensation authorities can encourage organisations to collect and share empirical evidence of the impact of their health, wellbeing, and organisational development activities on workplace stigma. Universities could also be involved in this process to ensure rigour in data collection and analysis. Stories of success must also be collected and recognised through awards and other jurisdiction-level events such as network groups and industry forums. Finally, there is an opportunity to examine how stigma reduction interventions can work synergistically to enhance the intensity and impact of other organisational initiatives.

We suggest further areas for future research to drive employer uptake of the recommendations outlined in this report and to encourage adoption of practices that build supportive, inclusive, and mentally healthy workplaces. Targeted research of this nature will significantly advance the field of stigma reduction and if supported by strong research translation capabilities, can be converted into practical recommendations and resources for insurers, WHS regulators, and employers to promote and implement.

In summary, stigma is a psychosocial hazard that negatively impacts the workers' compensation process. In Australia, stigma towards ill and injured workers may be chronic due to prevailing societal attitudes and stereotypes towards 'malingerers' in general. Therefore, we urge all organisations involved in injury management and compensation claims to review the findings of this project and support industry to make positive changes that benefit workers.

Attachment A

Guidance for employer communication and engagement

Based on the findings of this project, principles for effective communication with employers about stigma emerged. Each topic relevant to workers and employers is presented below.

Messaging to employers and workers

Understand the experience of stigma on others. Fact sheets for friends and family could be produced by workers' compensation insurers that describe the nature of 'courtesy stigma', whereby those supporting people could experience their own sense of stigma through association with the injured/ill worker. Such materials could include practical strategies to reflect on and minimise the psychological impact of courtesy stigma and provide referrals to other sources of support such as counsellors or injury management professionals.

Understand the experience of self-stigma. Workers may be unaware of the nature of self-stigma, and be confused, distressed, or anxious about the psychological experience of internalising negative stereotypes. Information and education about the nature of self-stigma, along with tips to manage it could be helpful to improve the experience of workers' compensation among injured/ill workers. Such information could help to normalise the experience of self-stigma, generate insight into the experience, and provide workers with strategies to reduce it, resulting in less negative impact on wellbeing and secondary injury/illness.

Understand the injury management process. Clarifying the injury management process can help to reduce the uncertainty and stigma-sensitisation that injured/ill workers tend to experience. Simplified flow charts of the workers compensation system and organisational injury management process, linking each stage to potential sources of perceived or anticipated stigma would be helpful to dispel myths about these processes. Additionally, it can help workers to make sense of signals such as long wait times, independent medical examinations, medical certificates, and other processes/practices that may be interpreted as stigmatising.

Proactive injury management. Workers may be tempted to conceal injuries/illnesses and continue working. This behaviour may be due to cultural beliefs (e.g., masculinity and toughness), a perception that the injury/illness 'isn't serious enough', or experiences of stigma within the organisation that impairs disclosure and help-seeking. Stories and examples of proactive injury management that involve early disclosure, treatment, and successful recovery could be used with workers to promote speaking up and seeking help for injuries and illnesses before they exacerbate and become difficult to treat and/or manage.

Highlight duties and obligations relating to stigma. Co-workers are often the source of either anticipated or experienced public stigma towards injured/ill workers. Co-workers, as well as injured/ill workers, would benefit from a clear list of what constitutes public stigma, along with the negative effects of such stigma on an injured/ill worker's health and wellbeing. Stories and quotes could be used to encourage empathy and perspective among co-workers and provide them with a compelling reason why they should change their behaviour and reduce discrimination. Linkages to psychological health duties and obligations, as well as equal opportunity and anti-discrimination legislation, could be another leverage point to highlight the potential legal implications of engaging in stigmatising behaviours. Regulators could consider a public advertising campaign on social media or other platforms, in partnership with well-recognised industry expert bodies (e.g., Beyond Blue, Black Dog Institute, SANE Australia), to build public awareness of injury/illness stigma.

Persons conducting a business or undertaking (PCBUs), such as employers, must eliminate or minimise risks to health and safety, including psychosocial risk, as far as is reasonably practicable. Workers also have duties under WHS laws. Workers must take reasonable care of their own health and safety in the workplace, and the health and safety of others who may be affected by what they do or do not do. Workers must also comply with any reasonable instructions, policies and procedures given by their employer at the workplace, including policies and procedures to reduce stigma in the workplace.

Emphasise workers' rights and responsibilities with injury/illness. For temporary or multicultural workers, and potentially many other Australian-born workers, there can be great hesitancy in speaking up and disclosing injury/illnesses. Such workers are often unaware of their rights and responsibilities regarding workplace health and safety, workers' compensation, and discrimination. Mechanisms for workers to report issues or mistreatment to the relevant regulator/authority would also be helpful and promote alternative pathways for stigma to be investigated and mitigated through enforcement activities if needed.

The process of disclosure and speaking up about injury/illness. Workers would benefit from education around how to have a conversation about disclosing their injury/illness in a workplace setting. Many could be unsure how to start the conversation, who to speak with, and what level of information to share. This makes workers less confident to speak up and creates barriers to reporting injury/illness.

Best practice principles for stigma reduction through communications campaigns

Communication and health promotion ideas and concepts can be used to help design programs that promote socially beneficial change such as stigma reduction and have already been applied to many of these initiatives with success.

According to Corrigan (2011), social marketing for stigma reduction can be highly effective because it allows for tailored messages that reflect content of stereotyped beliefs and attitudes, actively involves the audience in solving the stigma issues, and can be designed to change focus over time so that knowledge and attitude change are embedded, and behaviours sustained.

Through integrating the existing research around marketing campaigns for stigma reduction with the deliverables for this project, a series of best practice stigma reduction campaign principles were developed.

The best practice principles for communication and engagement relevant to the development of a potential future stigma-reduction campaign are as follows:

Highlight the benefits and value of stigma reduction. Key difficulties within injury/illness stigma contexts are that the benefits of engaging in stigma reduction may be delayed or apply more to a group or society rather than to the individual (i.e., the employer). In practice, this principle suggests that benefits must be conveyed to the target audience directly and be benefits that they truly value. Convincing evidence of business benefit, which is readily documented both anecdotally and through evaluation done by industry and researchers alike, can highlight the case for stigma reduction. Campaigns also need to acknowledge that consumers experience a cost associated with changing behaviour, so emphasising supporting resources and small industry grants/incentives or insurance premium discounts may be particularly effective in initiating change.

Leverage on existing, well-established concepts. To reduce the perceived costs of change and to avoid potential resistance when discussing stigma as a concept (e.g., employers insisting that stigma is a necessary control to discourage malingerers), stigma reduction campaign designers could leverage on existing topics and concepts that influence stigma in organisations. For instance, flexible work arrangement policies and practices can be used not only to drive lower business costs, increased productivity and workforce satisfaction, but also to assist with return to work and facilitating a less stigmatised recovery process (e.g., the injured/ill worker has more autonomy and control over their return-to-work plan). Psychological safety can also be leveraged as a useful concept given it has been shown to improve innovation and creativity, as well as general wellbeing, and could be applied to stigma reduction through promoting disclosure and help-seeking behaviours.

Bring the campaign to the audience. The locations in which stigma reduction is promoted must align with opportunities to influence and offer convenience to the target audience (e.g., through festivals, employer trade shows, television, and radio spots). Conference events that focus on WHS and/or wellbeing, and which regularly attract hundreds of business owners would be a prime vehicle for promoting stigma reduction. In previous international stigma reduction campaigns, interactive displays and immersive demonstrations and storytelling from persons with lived experience have been powerful ways of initiating change among key targets such as employers and policy officers.

Segment the audience and target the campaign. Audience research and profiling is important in stigma reduction settings because it helps to tailor messaging so that it aligns with the characteristics of target groups (e.g., current stigmatising attitudes and behaviours, readiness to change). For instance, with stigma reduction campaigns, business size will determine the types of messages that are likely to resonate with the target audience. For a small business, direct financial benefits that improve cash flow such as workers' compensation premium reductions, tender/contracting requirements by large clients (e.g., governments), and firm profitability are likely to generate behaviour change. For larger organisations, linking stigma reduction to corporate social responsibility, Board and shareholder expectations, and competitiveness are likely to generate change.

Involve persons with lived experience and create a two-way conversation. Contact exposure via ongoing and varied persons with lived experience is an effective tool to reduce stigma. It is vital that persons with lived experience of injury/illness and stigma in workplace settings are empowered to have a voice in social marketing campaigns. Going beyond contact exposure, persons with lived experience should be incorporated as experts into the design and development of social marketing campaign. Advisory groups can be established to provide feedback and reactions on draft campaign material and can be consulted to help formulate content (e.g., stories, experiences). Finally, two-way conversations between campaign designers and persons with lived experience ensures that practical challenges of stigma are intimately understood and can be used to shape the campaign over time as previous issues are surmounted and new ones arise (e.g., changing societal stereotypes around injuries/illnesses).

Use data and evidence to drive a compelling case for change that resonates with employers. Research supports the benefits of adopting a humanistic approach to organisational design and structuring. For instance, diversity and inclusion strategies are routinely shown to provide organisations with a strong competitive advantage and increased business performance (Shore, Cleveland & Sanchez, 2018). So, from an economic perspective, investing in people through creating a supportive and positive workplace environment that promotes inclusion makes business sense. This approach also resonates with employees who are likely to benefit from improved job satisfaction, engagement, and greater overall wellbeing. Using the research and findings presented in this report, workers' compensation insurers can develop compelling 'business cases for change' that increase awareness among employers and stimulate organisational improvement and transformation, which are then supported and reinforced by WHS regulators and associations/unions.

Adopt a perspective-taking approach. Through including rich stories and other dynamic and engaging media, campaigns to reduce stigma can promote empathy and understanding among the target audience. To do so effectively, highlight the similarities between the person with lived experience and the target audience, and ensure credible and relevant people are used in media (e.g., employers from similar industries to the target audience). Emotion can be used to convey powerful experiences and stories to the audience. By generating empathy, stigma reduction strategies are more likely to be effective.

Recognise and promote industry success stories. Consultation with Australian industries for this project revealed that many organisations are designing their own campaigns and tools to reduce stigma, particularly in the mental health space. Organisations are drawing on their employees who have lived experience to promote stigma reduction messages and act as a source of social support for people going through the injury management process. Examples such as these could be promoted by regulators and associations as case study examples and rewarded through considering them as part of industry wellbeing and WHS awards. Encourage such businesses to articulate the positive benefits they have achieved through targeting injury/illness stigma (e.g., workers' compensation premium reductions, more efficient and effective return to work). Also, a stigma reduction campaign can include stigma-related research and/or practice streams within existing wellbeing or WHS conferences to promote ongoing investigation and sharing of cutting-edge findings and recommendations.

Target messages at people with power and/or capacity to influence. Rather than broadcasting campaign messages broadly across the general public, designers of stigma reduction campaigns should target key groups (i.e., policy makers in Health departments and WHS regulators, unions, associations, and large employers such as government departments) and contextualise their communications and engagement strategies. For instance, large employers within specific industries can be identified and targeted for stigma awareness-raising and given more credible and context-specific resources (e.g., emergency services managers). Other influential stakeholders such as unions can be influenced to support their members to speak up about stigma and provide alternative dispute resolution or complaints pathways if the injury management matter needs to be escalated.

Monitor and evaluate progress. Continual monitoring of campaign effectiveness is recommended. At a macro level, existing national surveys such as the National Return to Work survey can be used to track the impact of social marketing campaigns relevant to stigma reduction. At a meso level, state and territory regulators can supplement broader measures of performance with localised survey questions and targeted consultation with industry advisory groups/committees. This formative and monitoring feedback will enable key messages to be refined over time, and emerging issues (e.g., presumptive legislation for injury/illness conditions, the impact of media stories about malingerers, government announcements) identified and woven into the ongoing campaign.

References

Australian Bureau of Statistics. (2018). Work-related injuries. Retrieved from https://www.abs.gov.au/statistics/labour/earnings-and-work-hours/work-related-injuries/latest-release

Beatty, J. (2018). Chronic illness stigma and its relevance in the workplace. In Stigmas, Work and Organisations (pp. 35-54). Palgrave Macmillan, New York.

Bikos, L. J. (2020). “It's all window dressing:” Canadian police officers' perceptions of mental health stigma in their workplace. Policing: An International Journal, 44(1), 63-76.

Bjorklund, R. W. (1998). First person account: Psychosocial implications of stigma caused by misdiagnosis. Schizophrenia Bulletin, 24(4), 653-655.

Boone, R. T., & Buck, R. (2003). Emotional expressivity and trustworthiness: The role of nonverbal behavior in the evolution of cooperation. Journal of Nonverbal Behavior, 27(3), 163-182.

Brewis, A., & Wutich, A. (2020). Stigma: A biocultural proposal for integrating evolutionary and political-economic approaches. American Journal of Human Biology, 32(4), e23290.

Brijnath, B., Mazza, D., Singh, N., Kosny, A., Ruseckaite, R., & Collie, A. (2014). Mental health claims management and return to work: qualitative insights from Melbourne, Australia. Journal of Occupational Rehabilitation, 24(4), 766-776.

Britt, T. W., Wilson, C. A., Sawhney, G., & Black, K. J. (2019). Perceived unit climate of support for mental health as a predictor of stigma, beliefs about treatment, and help-seeking behaviors among military personnel. Psychological Services, 9(1), 26-37.

Cameron, K. S., & Quinn, R. E. (2011). Diagnosing and changing organizational culture: Based on the competing values framework. John Wiley & Sons.

Clair, M., Daniel, C., & Lamont, M. (2016). Destigmatization and health: Cultural constructions and the long-term reduction of stigma. Social science & medicine, 165, 223-232.

Corrigan, P. W., River, L. P., Lundin, R. K., Penn, D. L., Uphoff-Wasowski, K., Campion, J., ... & Kubiak, M. A. (2001). Three strategies for changing attributions about severe mental illness. Schizophrenia Bulletin, 27(2), 187-195.

Côté, D., Dubé, J., Gravel, S., Gratton, D., & White, B. W. (2020). Cumulative stigma among injured immigrant workers: a qualitative exploratory study in Montreal (Quebec, Canada). Disability and Rehabilitation, 42(8), 1153-1166.

Dimoff, J. K., & Kelloway, E. K. (2019). With a little help from my boss: The impact of workplace mental health training on leader behaviors and employee resource utilization. Journal of Occupational Health Psychology, 24(1), 4.

Eakin, J. M., MacEachen, E., & Clarke, J. (2003). ‘Playing it smart’ with return to work: small workplace experience under Ontario’s policy of self-reliance and early return. Policy and Practice in Health and Safety, 1(2), 19-41.

Ellis, A. M., Casey, T. W., & Krauss, A. D. (2017). Setting the foundation for well-being: evaluation of a supervisor-focused mental health training. Occupational Health Science, 1(1), 67-88.

Goldman, B. M., Gutek, B. A., & Stein, J. H. (2006). Employment discrimination in organizations: Antecedents and consequences. Journal of Management, 32(6), 786-830. doi:10.1177/0149206306293544

Groot, C., Rehm, I., Andrews, C. … Blanchard, M. (2020). Report on findings from the our turn to speak survey: Understanding the impact of stigma and discrimination on people living with complex mental health issues. Retrieved from https://nationalstigmareportcard.com.au/sites/default/files/2020-10/NSRC_Full_Report.pdf

Hanisch, S. E., Twomey, C. D., Szeto, A. C. H., Birner, U. W., Nowak, D., & Sabariego, C. (2016). The effectiveness of interventions targeting the stigma of mental illness at the workplace: A systematic review. BMC Psychiatry, 16(1), 1-11. doi:10.1186/s12888-015-0706-4

Jiraporn, P., Potosky, D., & Lee, S. M. (2019). Corporate governance and lesbian, gay, bisexual, and transgender-supportive human resource policies from corporate social responsibility, resource-based, and agency perspectives. Human Resource Management, 58(3), 317-336.

Kirsh, B., Slack, T., & King, C. A. (2012). The Nature and Impact of Stigma Towards Injured Workers. Journal of Occupational Rehabilitation, 22(2), 143-154.

Kitchener, B. A., & Jorm, A. F. (2008). Mental health first aid training in a workplace setting: A randomized controlled trial [ISRCTN13249129]. BMC Psychiatry, 4(1).

Krupa, T., Kirsh, B., Cockburn, L., & Gewurtz, R. (2009). Understanding the stigma of mental illness in employment. Work, 33(4), 413-425.

Kulik, C., Bainbridge, H. T. J., & Cregan, C. (2008). Known by the company we keep: Stigma-by-association effects in the workplace. Academy of Management Review, 33(1), 216-230. doi:10.2307/20159384

Kvaale, E. P., Haslam, N., & Gottdiener, W. H. (2013). The ‘side effects’ of medicalisation: A meta-analytic review of how biogenetic explanations affect stigma. Clinical Psychology Review, 33(6), 782-794.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. Annual review of Sociology, 27(1), 363-385.

Lippel, K. (2007). Workers describe the effect of the workers' compensation process on their health: A Quebec study. International Journal of Law and Psychiatry, 30(4-5), 427-443. doi: 10.1016/j.ijlp.2007.06.013

Lippel, K. (2012). Preserving workers' dignity in workers' compensation systems: an international perspective. American Journal of Industrial Medicine, 55(6), 519-536.

Long, M. (2018). ‘We’re not monsters… we’re just really sad sometimes:’ Hidden self-injury, stigma and help-seeking. Health Sociology Review, 27(1), 89-103.

Lyons, T. (2017). Best practice review of Workplace Health and Safety Queensland: Final report. Retrieved from https://www.worksafe.qld.gov.au/__data/assets/pdf_file/0011/22322/best-practice-review-of-whsq-final-report.pdf

MacEachen, E., Clarke, J., Franche, R-L., & Irvin, E. (2006). Systematic review of the qualitative literature on return to work after injury. Scandinavian Journal of Work, Environment & Health, 32(4), 257-269.

Martins, L. L. (2020). Strategic Diversity Leadership: The Role of Senior Leaders in Delivering the Diversity Dividend. Journal of Management, 46(7), 1191-1204.

Milliken, F. J., & Martins, L. L. (1996). Searching for common threads: Understanding the multiple effects of diversity in organizational groups. Academy of Management Review, 21(2), 402-433.

Pachankis, J.E., Hatzenbuehler, M.L., Wang, K., Burton, C., Crawford, F., Phelan, J., & Link, B. (2018). The burden of stigma on health and well-being: A taxonomy of concealment, course, disruptiveness, aesthetics, origin, and peril across 93 stigmas. Personality and Social Psychology Bulletin, 44(4), 451-474.

Phelan, J. C., Link, B. G., & Dovidio, J. F. (2008). Stigma and prejudice: One animal or two? Social Science & Medicine, 67(3), 358-367.

Pichler, S., Blazovich, J. L., Cook, K. A., Huston, J. M., & Strawser, W. R. (2018). Do LGBT-supportive corporate policies enhance firm performance?. Human Resource Management, 57(1), 263-278.

Poteat, T., German, D., & Kerrigan, D. (2013). Managing uncertainty: a grounded theory of stigma in transgender health care encounters. Social science & medicine, 84, 22-29.

Price, M. (2017). Psychiatric disability in law enforcement officers. Behavioral Sciences and the Law, 35(1), 113-123.

PwC (2014). Creating a mentally healthy workplace: Return on investment analysis. Retrieved from https://www.headsup.org.au/docs/default-source/resources/beyondblue_workplaceroi_finalreport_may-2014.pdf

Roberts-Yates, D. C. (2003). Examining the role of rehabilitation in the South Australian workers' compensation system. The Australian Journal of Rehabilitation Counselling, 9(2), 82-101.

Safe Work Australia. (2018). National return to work survey 2018: Summary report. Retrieved from https://www.safeworkaustralia.gov.au/doc/national-return-work-survey-2018-summary-report

Safe Work Australia. (2021). Australian workers’ compensation statistics: 2018-2019. Retrieved from https://www.safeworkaustralia.gov.au/doc/australian-workers-compensation-statistics-2018-19

Sager I., & James C. (2005). Injured workers’ perspectives of their rehabilitation process under the New South Wales Workers Compensation System. Australia Occupational Therapy Journal, 52(2), 127-135. doi: 10.1111/j.1440-1630.2005.00477.x

Schein, E. H. (2010). Organizational culture and leadership (Vol. 2). John Wiley & Sons

Shann, C., Martin, A., Chester, A., & Ruddock, S. (2019). Effectiveness and application of an online leadership intervention to promote mental health and reduce depression-related stigma in organizations. Journal of Occupational Health Psychology, 24(1), 20-35. doi:10.1037/ocp0000110

Stergiou-Kita, M., Pritlove, C., & Kirsh, B. (2016). The "Big C" - Stigma, cancer, and workplace discrimination. Journal of Cancer Survivorship, 10(6), 1035-1050. doi:10.1007/s11764-016-0547-2

Summers, J. K., Howe, M., McElroy, J. C., Buckley, M. R., Pahng, P., & Cortes-Mejia, S. (2018). A typology of stigma within organizations: Access and treatment effects. Journal of Organizational Behavior, 39(7), 853-868. doi:10.1002/job.2279

Tarasuk, V., & Eakin, J. M. (1995). The problem of legitimacy in the experience of work-related back injury. Qualitative Health Research, 5(2), 204-221.

Thomson, S. B., & Grandy, G. (Eds.). (2018). Stigmas, work and organizations. United Kingdom: Palgrave Macmillan.

Tucker, J. M. (2015). Police officer willingness to use stress intervention services: The role of perceived organizational support (POS), confidentiality and stigma. International Journal of Emergency Mental Health and Human Resilience, 17(1), 304.

Tyler, I., & Slater, T. (2018). Rethinking the sociology of stigma. The Sociological Review Monographs, 66(4), 721-743.

Van Brakel, W. H. (2006). Measuring health-related stigma - A literature review. Psychology, Health & Medicine, 11(3), 307-334. doi:10.1080/13548500600595160

Van Laar, C., Meeussen, L., Veldman, J., Sterk, N., Van Grootel, S., & Jacobs, C. (2019). Coping with stigma in the workplace: Understanding the role of threat regulation, supportive factors, and potential hidden costs. Frontiers in Psychology, 10, 1879.

Vornholt, K., Uitdewilligen, S., & Nijhuis, F. J. N. (2013). Factors affecting the acceptance of people with disabilities at work: A literature review. Journal of Occupational Rehabilitation, 23, 463-475. doi:10.1007/s10926-013-9426-0

Webster, J. R., Adams, G. A., Maranto, C. L., Sawyer, K., & Thoroughgood, C. (2018). Workplace contextual supports for LGBT employees: A review, meta-analysis, and agenda for future research. Human Resource Management, 57(1), 193-210.

Appendix

Systematic literature review method

Search Strategy

Articles were obtained via ProQuest Central and Web of Science Core Collection using the search string (work* OR employm* OR employee) AND (stigma OR discrimin* OR fear OR reluctance OR prejudice*) AND (ill* OR injur*) AND (interven* OR training OR initiative OR trial OR strategy OR plan). Article records including titles, authors, publications, and abstracts were downloaded into an EndNote template for systematic reviews. Initially, 2,908 articles were located for further refinement. Duplicates were then removed, leaving a total of 1,589 articles for screening.

Screening occurred via the Rayyan platform. Two members of the research team independently reviewed the title and abstract of the articles. Articles were marked ‘include’, ‘exclude’, or ‘undecided’ based on the following criteria:

1) Described an intervention study

2) Directly related to workplace mental health stigma (broadly defined)

3) Published in scholarly journals within the period 2010-2020

The review was unblinded once the two researchers independently made decisions on all articles. A third member of the research team acted as adjudicator to determine the inclusion or exclusion of articles marked ‘maybe’ or on which there was a conflict in decision-making.

Articles included at the abstract screening stage were obtained and assessed for inclusion in the full-text review. A total of 20 articles were included at this stage, with three removed due to limited relevance to workplace contexts. To expand the quality and reach of our review, an additional 14 articles were sourced from the reference lists of existing workplace stigma-reduction reviews and the results of a Google Scholar search. This ‘snowballing’ technique is considered a valid and powerful technique to collect additional evidence for inclusion in systematic reviews and can even double the number of considered articles (Greenhalgh & Peacock, 2005). Consequently, a total of 31 articles were included within the review.

Synthesis of the Results

To extract trends and insights from across the selected articles, a combination of basic descriptive statistics and qualitative content analysis were conducted. Specifically, we identified quantitative trends by computing averages and percentages of various study types and categories. Then, we summarized each study using a structured spreadsheet and identified common themes across several areas, such as intervention characteristics, outcomes, research design and quality, and participants and sample.

Quality Assessment

To evaluate study quality, each selected paper was subjected to a structured assessment using the Effective Public Health Practice Project 'Quality Assessment Tool for Quantitative Studies' (Armijo-Olivo et al., 2012). Two researchers independently reviewed the list of articles and evaluated the quality of each article using this tool. Before discrepancies were reconciled, a reliability index was computed using Krippendorf's alpha. The value was 0.80, which is within the 'substantial' range of agreement according to the recommendations of Landis & Koch (1977). After this independent rating process,

Consultation interview protocol

Background

- Employment details
- Past experiences/work history
- Education and training

Problem definition

- What does stigma towards injured/ill workers look like in your organisation?
- What problems does this stigma create for your organisation?
- Why did your organisation decide to do something about this stigma?

Solutions

- What steps did your organisation take to identify a solution?
- What desired outcomes or changes was your organisation hoping to achieve?
- What did your organisation do to reduce stigma?
- How was the solution received by the workforce?

Outcomes/benefits

- What measures or metrics were used to evaluate the solution?
- What outcomes and benefits have been achieved so far?

Challenges/learnings

- What contributed to the solution's success?
- What may have detracted from or reduced the solution's success?
- If you had your time again, what would you do differently?
- What would you recommend to organisations who are starting to address injury/illness-related stigma?

Next steps

- What do you see as the potential next steps for stigma reduction?
- What resources and help would be beneficial for the next step?

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