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Module:	**12: Mental health and wellbeing in the agricultural sector**

12 Module 12 Mental health and wellbeing in the agricultural sector

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12.1 Introduction

Aims of the Module:

- This Module aims to aims to cover mental health issues in the entire agricultural sector. It specifically focuses on the farming sector, with its preponderance of family owned and very small enterprises rather than on the much larger enterprises that can be found in food processing and production sectors. In many ways, these larger enterprises have in common many of the features to be found in large enterprises in any economic sector, but the smaller enterprises in the farming sector present a unique challenge for the practitioner.
- This chapter is targeted at two specific types of OSH practitioner – occupational physicians and health and safety experts. While there are variations in the way these practitioners operate, for current purposes the material presented here is relevant to both. The chapter is also relevant for other occupations involved in managing health and safety in the agriculture workplace, such as human resources managers, agricultural advisers and public health specialists.

Overview of contents:

- Chapter 2 of this Module addresses the issue of mental health and wellbeing – it distinguishes between mental health, mental illness and mental wellbeing, terms which are often confused.
- Chapter 3 presents the economic or business case for addressing mental health and wellbeing issues at work – it points to the costs for employers that currently exist and presents evidence that suggests that intervening in the workplace can bring cost savings to employers.
- Chapter 4 highlights the evidence that is available for the existence of mental health problems amongst employees in the farming sector. It deals with issues relating to suicide and mental health issues in general.
- Chapter 5 addresses some of the unique features of farms that distinguish them from other workplaces and outlines some of the main psychosocial risks in farming.
- Chapter 6 presents a European methodology for assessing psychosocial risks in the workplace. It addresses the major types of psychosocial risk to be found in the workplace and the types of intervention that can be made and their effectiveness.
- Chapter 7 draws on the literature on mental health interventions in the farming sector and examines in more detail the how they might be applied in the European farming context.
- Chapter 8 presents the main conclusions from the Module and identifies the main challenges to OSH and occupational medical services to delivering an effective response to mental health issues in the agricultural sector workplace.
- Throughout the Module continuous reference is made to the implications if general findings on mental health issues at work for the agricultural sector. Attention is also drawn to how these findings challenge OSH and occupational medical services to develop creative responses to the issues.

Learning outcomes:

After studying this module the trainee should be able to:

- understand the concepts of mental health and wellbeing and mental illness
- be aware of the manifestations of mental health issues in the agricultural workplace
- be aware of how to conduct a psychosocial risk assessment for occupational stress in agricultural workplaces
- be aware of OSH, WHP and RTW issues in relation to mental health issues in the workplace
- be able to construct a cross-settings approach to mental health issues in family farms

Background

The issue of mental health and wellbeing in the agricultural sector has attracted increasing attention in recent years in many countries, including Ireland, the UK, Australia and New Zealand. Headlines have been made in relation to farmer suicides as well as apparently increasing levels of mental health difficulties amongst farmers and people in rural areas. As a result, there have been efforts to intervene to improve mental health and wellbeing that have used either (or both) OSH related and public health based approaches to the issue.

Dealing with mental health issues is difficult compared to more traditional workplace based health related problems for a variety of reasons.

- **Problems of causation** – there are multiple factors which cause mental health breakdown many of which emanate from outside of the workplace. This limits the legal responsibility of workplaces to prevent and manage mental health issues to those factors that occur only in the workplace. However, focusing solely on workplace related factors is unlikely to be completely effective in managing the issue. This presents a challenge to OSH services and policy.
- **Stress and mental health** - occupational sources of stress are typically difficult to quantify and manage in comparison to more traditional sources of occupational risk. Risk assessment is more difficult and the interventions that are required are potentially more complex. In addition, many of the factors which cause greatest stress for farmers and agricultural workers are beyond their control, e.g. problems with the weather or disease on the farm.
- **Farming and agricultural related issues** – much of farming in Europe is carried out in very small organisations, often on family owned farms. The stresses faced by farmers often relate to both business ownership as well as to the nature of the work itself. In addition, the farm workplace is often the location of the farmers' home and (often extended) family. This arrangement is almost unique amongst workplaces in Europe.
- **Problems of capacity** – Given the small size of most agricultural enterprises (be they farms or other types of enterprise such as food producers), there is likely to be a problem with the capacity of these enterprises to engage fully in OSH, Workplace Health promotion (WHP) or rehabilitation and Return to Work (RTW) practice. In part this is a problem of training and expertise, but it also relates to having the time and human resources available to undertake these activities.

These issues, though not individually unique to the agricultural sector, nonetheless collectively demand that an imaginative approach is taken to deal with mental health in agricultural enterprises and farms. Such an approach should be able to deal with the nature of the phenomenon itself (i.e. mental health problems) as well as the combination of the remoteness of many agricultural enterprises and the difficulty of delivering services into very small or one person enterprises while building on the strengths and resources that are to be found in rural enterprises both within and outside the enterprise itself.

These issues present a challenge to occupational health services generally and to occupational medicine in particular. Traditional models of delivery of services are not sufficient to cover the workforce in the agriculture sector, given the geographical difficulties associated with rural area., In addition, the nature of family and small farms, with integration of work and home life, often across generations presents both occupational and public health challenges that require an integrated response to service delivery. Furthermore, the nature of mental health problems and the cultural issues which surround them in rural

areas and the agricultural sector demand an integrated approach from both the health sector and the communities from which farm and agricultural sector workers are drawn.

12.1.1 Glossary

Term	Definition
Return on Investment	Return on Investment (ROI) is the benefit resulting from an investment of some resource such as money
Mental health	Mental health can be understood as a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community
Benefit-cost ratio	The ratio of the benefits of a project or proposal, expressed in monetary terms, relative to its costs, also expressed in monetary terms
Work Ability	This refers to a combination of the physical and mental health and wellbeing of an individual and their capacity to work. Derived from the Finnish concept of Maintenance of Workability.
Mental health promotion	Actions taken to improve or maintain mental wellbeing, be they individually or situationally oriented
Rehabilitation	The process of returning a person to health and wellbeing following health breakdown
Return to work	The processes that are undertaken within the workplace and outside of it to enable an individual to get back to work following health breakdown.
Health and Safety Authority	Ireland's national health and safety agency and labour inspectorate.

12.2 What is mental health and wellbeing?

There is often confusion around the definitions of and relationships between mental health, wellbeing and mental illness. In addition, there is similar confusion around issues concerning stress, occupational stress and their relationships to concepts of mental wellbeing. In this section, these concepts are defined in order to be clear about their operation in relation to the agricultural sector workplace. Wynne et al (2015) address these issues in a set of guidelines on how to address mental health and wellbeing in the workplace.

To begin with, the World Health Organisation's definition of **health** (WHO, 1946) states that:

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"

This definition recognises the mental, physical and social dimensions of health. In addition, it recognises that health does not just refer to the absence of disease or illness, but that health is a more positive state which involves wellbeing.

Specifically in relation to **mental health**, the WHO (2001) provides the following definition:

"Mental health can be understood as a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community".

In this context the normal stresses of life refer to stress arising from areas such as the workplace, home life, family life, finances, major life events etc. In the context of the agricultural setting, issues which stand out would include the fact that workplace and home based stressors are often difficult to untangle and that the opportunities for contributing to social life may be limited. Working '*productively and fruitfully'* may be beyond the control of farmers due to the unpredictability of many of the demands that they may face.

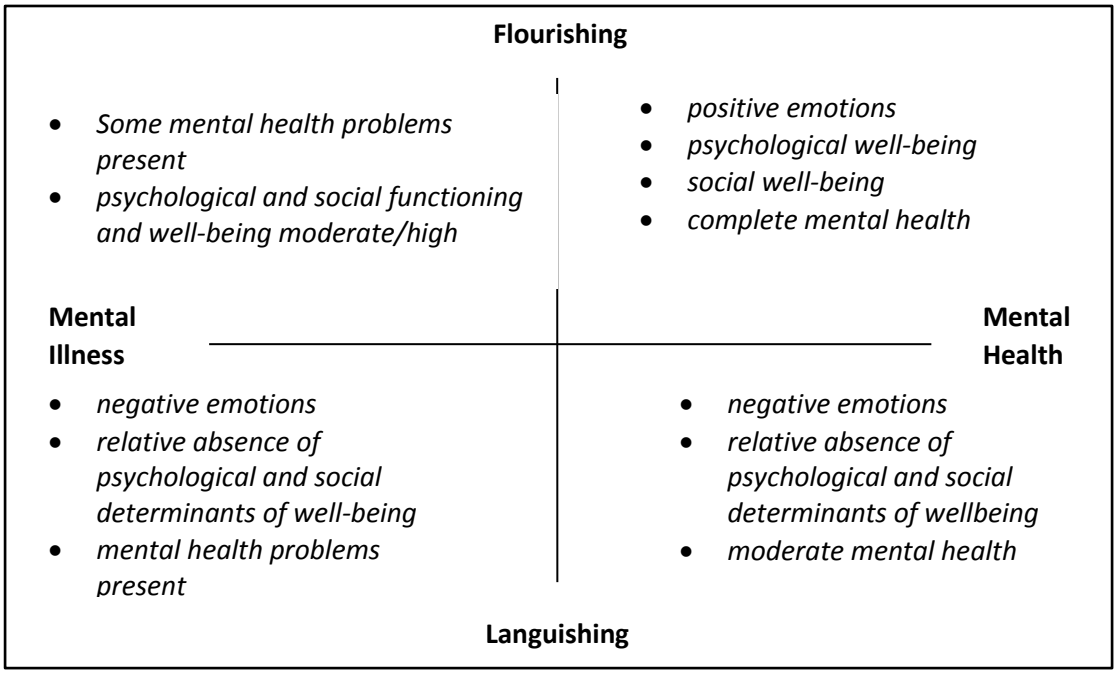

Figure 12-1 Continuum of mental health (Adapted from Keyes, 2002.)

12.2.1 Positive mental health and wellbeing

A key implication of the WHO definitions is that absence of disease or problems does not necessarily mean that health is good. Mental wellbeing is a commonly used concept in recent times and seeks to recognise that there is a positive side to mental health which is distinct from mental illness. It is a state of wellbeing that is characterised by feeling well, having fulfilling relationships, as well as having the ability to cope, while maintaining a positive outlook on life. Mental health influences how people think, communicate, learn and grow. Mental wellbeing strengthens resilience and self-esteem. These are the psychological and social factors that enable the individual to become successfully involved in the community, in society, in occupational life and in relationships.

Mental health and mental illness have often been described as points on a continuum. However, research suggests that there are two continuums to be considered and that the absence of mental illness may not always be reflective of genuine mental health (see figure 1). The continuum of 'flourishing and languishing' (Keyes, 2002) takes a positive approach to mental health and proposes that a person may still flourish even in the absence of full mental wellbeing.

This approach is important in the context of mental health promotion – the process whereby positive mental health and wellbeing is maintained or improved.

12.2.2 Mental health problems and disorders

Mental health problems (less serious disruptions to mental wellbeing) are fairly common and are often experienced during periods of high stress or following upsetting events. For example, bereavement

symptoms of less than two months' duration do not qualify as mental disorders. Nevertheless, bereavement can become debilitating if the individual receives no support during this period and it may also be necessary for the bereaved person to attend counselling during this time. Active efforts in mental health promotion, prevention, and treatment can significantly reduce an individual's risk of developing a mental illness.

12.3 The costs of poor mental health

There are significant costs to be borne in relation to poor mental health and wellbeing. For the individual, these occur in terms of lost income and increased treatment costs. However, there are significant costs to workplaces of poor mental health in Europe. It has been estimated that the overall costs of 6 commonly occurring mental health conditions amounted to almost €800 billion in 2010 (Gustavsson et al, 2011). Workplace related costs, i.e. the costs of absences account for almost 40% of these costs. Table 1 below shows the estimates for costs for these 6 illness types.

Table 12-1 Cost estimates of 6 commonly occurring mental illness types (€billion)

(Adapted from Gustavsson et al, 2010).

Type of illness	Direct health care costs	Direct non—medical costs	Indirect costs1	Total
Addiction	27.7	13.6	24.4	65.7
Anxiety disorders	46.3	0.1	28.0	74.4
Dementia	17.0	88.2	NA[2]	105.2
Headache	9.0	NA	34.5	43.5
Mood disorders	26.0	15.4	72.0	113.4
Psychotic disorders	29.0	NA	64.9	93.9
Other[3]	141.4	68.9	91.3	301.6
Total	296.4	186.2	315.1	797.7

The authors point out that many of these mental health conditions are potentially avoidable – as much as €150-200 billion could be avoided with appropriate workplace policies. As part of the background documentation to the Mental Health Pact (McDaid, 2008), it was estimated that the total productivity costs of mental health in the EU-25 and the EEA area in 2007 were of the order of €136 billion, €99 billion of which was linked to depression and anxiety related disorders. These costs were contrasted to the productivity losses due to cardiovascular disease, which amounted to approximately €36 billion.

Though these two studies used somewhat different methods to arrive at these estimates, it is clear that the costs to European employers of mental health disorders are very high and considerably higher than the other main illnesses associated with absenteeism. It should also be noted that it has also been estimated (cited in McDaid, 2008) that the costs of presenteeism due to mental health disorders could be between 50% and 500% of absenteeism costs.

[1] Indirect costs refer mainly to absenteeism costs
[2] NA – No data was available
[3] Other illnesses refer to a wide range of conditions such as brain injury, brain tumour, sleep disorders and many more

Given that many studies point to the vulnerability of people working in the agricultural sector, it is clear that mental health issues carry significant economic costs to farming and agricultural enterprises.

If the costs of mental health to the workplace are high, then there is also evidence that making interventions at workplace level carries considerable return on investment. Recent work in the UK and for the European Commission provides insight into the cost savings that can be made through targeted interventions in the workplace (e.g. Matrix, 2013; National Institute for Clinical Excellence, 2009).

The NICE study (UK data) has concluded that the Return on Investment (ROI) of undertaking workplace health promotion as a means of addressing mental health issues results in a return in investment to the health sector of almost 10:1. This is almost twice the ROI of early diagnosis and treatment of depression at work and almost as high as early diagnosis of psychosis or screening for alcohol abuse.

The Matrix study cited UK data that showed positive ROIs for specific types of intervention at the workplace to employers and employees – workplace improvement programmes, specific types of therapies and stress management programmes all resulted in positive ROIs in relation to the costs of mental health in the workplace. Table 2 below (adapted from the Matrix study) shows the benefit-cost ratios for examples of universal (i.e. available to all employees), targeted (interventions aimed at specific groups) and treatment (interventions aimed at people who have developed depression). The Table clearly shows that there are cost benefits to be gained for all 6 intervention types and that employers generally benefit more than the other sectors.

Taken together, these findings provide a powerful economic case for addressing mental health issues in the workplace. They relate only to the issue of depression, but they illustrate a number of important issues in dealing with mental health issues at the workplace:

- There is a benefit-cost case to be made that all sectors of the economy; both private and public benefit from making interventions in relation to depression. Employers in particular and the economy as a whole benefits as does the health care system.
- The interventions that make the biggest differences in terms of cost-benefits are not necessarily directly targeted at depression, e.g. exercise for people with depression and general workplace improvements

Finally, though these findings do not relate directly to the agricultural sector, there is enough anecdotal evidence to suggest that the economic impacts on farmers of poor mental health make the economic case of prevention and treatment compelling for this sector also.

Table 12-2 Benefit-cost ratios for different kinds of interventions to reduce depression (adapted from Matrix, 2012)

	Universal		**Targeted**		**Treatment**		
	Workplace improvement	*Acceptance and commitment therapy*	*Stress management*	*Email CBT*	*Exercise*	*CBT*	
Effect on depression rate	-34%	-80%	-45%	-25%	-72%	-43%	
Benefit-cost ratio by sector							*Overall*

	Universal		Targeted		Treatment		
Healthcare system	2.94	1.60	0.20	0.11	1.80	0.64	7.29
Social welfare system	0.47	0.26	0.03	0.02	0.29	0.10	1.17
Economy	5.03	2.73	0.37	0.21	3.12	1.12	12.58
Employers	3.36	5.66	0.81	0.47	8.42	3.04	21.76
Overall cost-benefit ratio	11.79	10.25	1.41	0.81	13.62	4.91	

12.4 The prevalence of mental health issues in the agriculture sector

It has been reported that the most frequent mental disorder in the EU is major depression (affecting 6.9% of people; Mladovsky et al., 2009; Wittchen et al., 2011). Anxiety is reported to be a major issue, while only relatively small numbers of people experience more severe mental illnesses such as the psychotic disorders. Moreover - the rates of mental disorders in different countries do not differ substantially (Wittchen et al., 2011).

The European Commission found that in the EU27 15% of people had looked for help for a psychological or emotional problem, and that as many as 72% of people had taken antidepressants at some point in their lives (European Commission, 2010). The Mental Health Foundation in the UK suggest that as many as 25% of people may be affected by a mental health problem in any one year (Mental Health Foundation, 2015).

However, many people with mental health disorders are not part of the labour market due to the severity of their difficulties. The OECD (2012) and others provide estimates of the proportion of the workforce that are living with a mental health issue – they estimate that this may be 20% of the OECD workforce. Wittchen et al (2011) estimate that as many as 40% may be living with a mental health problem.

There has been relatively little research in relation to the prevalence of mental health disorders among the farming community, or more broadly people working within the agricultural sector. However, the evidence that is available would suggest that psychological difficulties and mental health disorders are at least as high as elsewhere on the labour market. In addition, the issue of suicide amongst farmers has been the subject of investigation in recent years, due to the perception that suicide rates may be higher than in other occupations.

12.4.1 Suicide amongst farmers

There have been a number of studies which have investigated suicide rates amongst farmers in the past twenty years. Fraser et al (2005) undertook a systematic review of the literature on the issue since 1985 and could find only 9 papers (English language) that dealt with suicide. They concluded on the basis of these that some groups of farmers have higher suicide rates than the general population, but that conclusive data did not then exist to indicate that farmers (or their families) were subject to higher rates of mental health problems than the non-farming community.

A more recent review by Naik (2016) points to studies that indicate a higher rate of suicide amongst farmers. In the UK, England's national suicide strategy identifies farmers as being a high risk occupational group (UK Department of health, 2012). In addition, British farmers are more than twice as likely to contemplate suicide when compared to the general population (Thomas et al 2003). In the US, farmers, foresters and fishermen

have the highest suicide rate of any occupation (McIntosh et al 2012). Farmers in France have a 20% excess rate of suicide compared to the general population (Bossard, 2013).

In Ireland, Cleary et al (2012) undertook a qualitative study of 26 men who had attempted suicide that had been admitted to a Psychiatric unit and who came from rural areas. Factors that were associated with suicide attempts included lower socio-economic status, lower educational levels, limited job opportunities, multiple job histories marginal farming and dependence on social welfare payments. In addition, 80% of the group had a previous history of depression.

12.4.2 Mental health and wellbeing amongst farmers

There is also evidence available in relation to the issue of mental health and wellbeing amongst farmers. Though Fraser et al in 2005 did not find conclusive evidence of raised levels of mental health difficulties and called for more research, other authors since then have produced more conclusive evidence on the issue. For example, Hounsome et al (2012) in a UK study found that psychological morbidity (as measured by the GHQ-12) was significantly higher amongst farmers and their partners/spouses when compared to the general population – 35% scored 12 or higher (the recommended cut-off for psychiatric disorders) compared to 27% in the general population. In particular, being male, aged 45-64, self-employed, not being in paid employment and having a non-supervisory position were all associated with higher rates of psychological wellbeing.

Saarni et all (2008) in a Finnish study of a nationally representative sample of farmers found that they had lower Work Ability and health related quality of life (HRQol) and that these deficits were mainly due to '*poorer functions in the psychosocial domains of HRQol*'. They conclude that '*from a public health point of view, improving farmers' wellbeing may require psychosocial interventions exceeding traditional health promotion'*.

12.5 The agriculture and farming context

Farming and agricultural enterprises cannot be separated from their wider communities and locations when considering mental health issues amongst agricultural sector workers. Some of the issues that are relevant here include:

- Economic changes
- Population changes in rural areas
- Reductions in rural services, including health, health and safety
- Move towards business farming models
- Small business pressures
- Establishing and maintaining a family in sparsely populated areas
- Changing gender roles – women becoming more active in farming tasks and balancing this with family demands
- Farming culture

There have been significant and accelerating economic changes in the past decade or so that have affected farming and agricultural enterprises. These have varied from country to country, but common themes include the economic failure of family farms with consequent knock-on effects on rural enterprises, the move towards farms becoming small businesses rather than family run enterprises, and the subsidy regimes that operate in the farming sector. In general, there has been a fall in number of famers and a continuation of low incomes for farms. In general, farming has become more marginal in economic terms for traditional style farming, in many countries such as the US, the UK and Ireland (see for example, Donham and Thelin (2016); Farm Business Survey UK (2016 Ongoing); Hennessey, T. and Moran, B. (2016)). Moreover, it is clear from this work that incomes can vary dramatically between farming sectors, regions and across time - even if there are relatively good years they may be followed by large reductions in income on following years.

This variability and unpredictability of income has led to the same financial pressures on farmers that may result in mental health problems for any small business person and there is mounting evidence that farmers are at risk of disruptions to mental health, more serious psychological problems and to suicide (e.g. Fraser et al, 2005; Hounsome et al, 2012; Kolstrup et al, 2013; Goffin, 2014; Naik 2016; Cleary et al, 2012; Thelin and Donham, 2016).

A related phenomenon to economic decline in the farming sector is that of rural depopulation and general demographic change. This is a worldwide phenomenon, whereby people living in rural areas are attracted to the better economic opportunities available in the cities and towns. There have been a number of facets and effects of this trend. On the one hand, it is mostly younger people who migrate (or even emigrate) to urban areas, which leads to the ageing of the farming workforce (In Ireland, farming has the oldest workforce of any sector), but it also leads to the decline of social infrastructure in rural areas (e.g. closure of schools, banks, post offices, recreational facilities and social opportunities for younger people). Taken together, these trends make the occupation of farming less attractive to younger people while also making the countryside a less attractive and viable place for young people to live and work.

Another element of farming life that affects some countries more than others concerns the tensions that may exist within family farms over the running of the farm between the generations. Younger farmers tend to be better educated than their parent's generation (e.g. in Ireland most young farmers now have agricultural education, often to degree level, whereas this was area on the previous generation). An additional source of tension may arise from the trend towards increasing numbers of female farmers – this may lead to tensions between genders as well as between generations.

A feature of rural life in many countries is that State Services tend to be spread thinly and are consequently more difficult to access. This is true for health services, education and environmental services. In the context of occupational health safety, there is also evidence that such services are thinly spread, even if there is a proportionately greater need for effective services in the farming sector. Though such services tend to focus on the high level of physical and chemical risks that can be found within farming, their scarcity means that psychosocial risks to mental health receive even less attention than they do in the general economy.

Personal factors may also influence the risks that farmers face in relation to developing mental health problems. In addition to the personal factors that all sectors face, it has been noted that the coping styles of farmers tend not to be social in nature i.e. they tend to be individualistic in approach. This leads to a lack of communication with people who may be able help when such help is needed – farmers tend to be poor at taking up social support.

A recent study on mortality amongst Irish farmers (Smyth et al, 2012) dramatically reveals the cumulative effect of these (and other) factors on the mortality of farmers. Standardises mortality ratios (SMRs) were calculated nationally between the years 2000 and 2006 for farmers and all other occupational groups. Results showed that farmers were more than times more likely to die from all causes of death (agricultural workers had a ratio of 7.35) than the lowest risk occupational group (salaried workers). Farmers SMR was equal to that of the unskilled worker group. Moreover, they had higher SMRs for circulatory diseases, cancers and injuries and poisonings, and these SMRs worsened considerably over the period 2000-2006. The factors that were associated with higher SMRs in this study were the size of the farm (small farmers were more at risk), high levels of economic dependency, lower education levels and being at risk of poverty. Though this study did not specifically look at mental health issues it is clear that farmers and agricultural workers are at very high risk of early death. The data on injuries and poisonings (at least some of which would be linked to mental health issues). Overall, the authors point to the difference between their findings i.e. that in this period, the SMR of farmers was increasing compared to the general finding that farmers tend to be healthier than the general population. They point mainly to issues of falling incomes and the increasing marginalisation of farming as an economic activity, even at a time when the economy was growing very strongly, as being the main cause of the dramatic worsening of mortality statistics.

12.5.1 Psychosocial risks in farming

Recent studies have pointed to sources of psychosocial risk that are especially prevalent in farming (e.g. Fraser et al, 2005; Gregoire, 2002; Thomas, 2003; Onwuameze et al, 2013; Sarni, 2008; Canton and William, 2012; Leonard 2015). While these risks are not distributed evenly in all sectors of farming, and some are more relevant in one or another country, there is a consensus that many of the following risks are in excess in the farming sector:

- Long hours and more intense work
- Seasonality – managing extra labour during harvest time
- Dairy farming and long hours
- Weather – heat, cold, climate disasters
- Animal/plant disease outbreaks
- Working alone, loneliness/lack of social contact
- Intergenerational issues in farm families
- Technologies and machinery
- Bureaucracy
- Inspections by authorities
- Financial pressures
- Lack of understanding of the realities of farming – town versus country
- Short or no holidays

A recurrent theme on the literature concerns the length of time that farmers must work in order to meet work demands. It would appear that many farmers must work long hours in order to meet work demands, but the amount of effort varies according to the type of farming engaged in and the time of year (seasonality of the work). Typically, dairy farming involves working 365 days per year at specific times of day, but little seasonal variation (though workload increases during the calving season). For crop farmers, workload is more seasonal, with big peaks on workload during harvesting. In addition, harvesting brings on the added pressures of locating and managing extra labour or getting access to machinery contractors, all of which can lead to increasing the levels of stress that farmer experiences. A related issue to long working hours concerns the difficulties that many farmers have in taking holidays. This is an especially acute problem for those such as dairy farmers who have no naturally occurring reductions in workload at any time of year.

Factors that are beyond the control of the farmer are also significant. Recurrent themes here include machinery breakdown, especially at times when it is in high demand, getting access to the services of agricultural contractors (for example during harvest time) and the impact of severe weather conditions have all been mentioned in the literature as being stress inducing. Outbreaks of plant and animal disease are also significant here.

Two parallel forces have combined to increase the demands on farmers (and small food producers) in relation to paperwork and bureaucracy – the move towards farms becoming small businesses and the increasing regulation of farming and food production from both national and EU sources. The requirement for farms to keep financial records for business and tax purposes as well as the bureaucracy associated with obtaining farm subsidies and supports has led to more stress from these 'non-traditional' farming sources. In addition, food safety regulations are also associated with high levels of paperwork and inspections for both farmers and food producers and these also can lead to the stress load that they face.

One further factor that operates as a stress factor for many farmers is noise induced hearing loss – leaving aside the impacts on hearing, it can also contribute to increased isolation and mental distress. This is in addition to the strains imposed by social isolation, not only at work, but also in rural areas generally. An element of this isolation is the lack of social support from fellow workers, where either these do not exist or are isolated from each other. This lack of social support increase the risk of stress impacting on the health and wellbeing of the farmer.

Many farmers are subject to stress that arises from financial difficulties. As more and more farms are being run as businesses, the need for credit to run the farm becomes more acute. However, cash flows are unlike those for small businesses in other sectors, as income is often seasonal (particularly for those involved in crop production). Poor harvest, machinery breakdowns and other unpredictable expenses place increased financial pressure on farmers and these have often been cited as a factor in the farmer suicides.

Finally, it should be noted that farmers are not subject to single sources of stress – many of these sources of stress interact to produce higher levels of risk for mental health breakdown. It has been suggested that it is the presence of these interacting stressors is more important than the action of any single stressor that creates the highest risk. (Kennedy et al, 2014; Goffin, 2014).

In Australia and New Zealand, considerable effort has been spent in developing integrated approaches to the stresses that exist in farming and rural life. Bodies such as the New South Wales Rural Mental Health Network (Aghealth, undated) and DairyNZ's wellness and wellbeing programme (RHAANZ, 2013) have taken systematic approaches to the issues involved. Both programmes stress the importance of monitoring risks on a continuous basis as well as benchmarking mental health related outcomes over time and in comparison with other occupational groups. The new South Wales Blueprint for Farmers Mental Health points to 13 common sources of psychosocial risk in farming (most of those treated above) as well as alcohol misuse, poor mental health and low resilience amongst farmers, access to firearms, and lack of knowledge and insight on the part of rural health services regarding issues of mental health.

Reflection/exercise: Profiling the main farming sector issues in your country
Given the nature of farming in your country, what specific elements of farming culture and working conditions might be leading to mental health problems for farmers?

12.6 Risk assessment for occupational stress

The Framework and related Directives place risk assessment at the heart of the health and safety process. In line with these, this Section deals with the issue of how to undertake risk assessment in relation to psychosocial hazards associated with mental health in the workplace. Other risks to mental health can come from physical or chemical hazards and these may interact with psychosocial risks. All known risks to mental health should be the subject of risk assessment.

12.6.1 What are the major psychosocial hazards in the workplace?

There are many models of stress at work[4] which point to the kinds of psychosocial hazard that may be encountered in workplaces. Research on psychosocial hazards has taken place for more than 40 years and there is broad agreement on the nature of these hazards as well as on the theories of how they affect the health of the individual and other outcomes such as productivity, quality of work, job satisfaction and absenteeism.

The PRIMA-EF project (Leka and Cox, 2008; WHO, 2009) funded by the European Commission, proposed a European Framework for Psychosocial Risk Management. As part of this work, it refers to 10 major types

[4] It should be noted that psychosocial hazards at work are not equivalent to stress at work – if they are not prevented they may lead to stress related outcomes (such as poor mental or physical health).

psychosocial hazards that may exist in the workplace – see Table 3. These refer to any type of workplace, though some are more relevant than others for any specific workplace. In the context of small workplaces in the agricultural sector workplaces, many or all of these could potentially apply. In the case of family or small farms, some specific issues have been demonstrated to apply. For example, high uncertainty about the outcomes of work (job content); high levels of workload, especially at peak times of the year, and being subject to time pressures and deadlines over which the farmer has little control (workload and work pace); and long working hours (work schedule) are all relevant. So too are issues such as lack of social interaction (relationships at work); lack of control over workload (control); and stressful interactions between the farmer and the rest of the farm family (home-work interface, career development).

Table 12-3 Psychosocial hazards in the workplace

Type of hazard	Definition
Job Content	Lack of variety or short work cycles, fragmented or meaningless work, under use of skills, high uncertainty, continuous exposure to people through work
Workload and work pace	Work overload or underload, machine pacing, high levels of time pressure, continually subject to deadlines
Work schedule	Shift working, night shifts, inflexible work schedules, and unpredictable hours, long or unsociable hours.
Control	Low participation in decision making, lack of control over workload, pacing, shift work etc.
Environment and equipment	Inadequate equipment, availability of equipment, suitability or maintenance, poor environmental conditions such as lack of space, poor lighting, excessive noise
Organisational culture and function	Poor communication, low levels of support for problem solving and personal development, lack of definition of, or agreement on organisational objectives
Interpersonal relationships at work	Social or physical exclusion or isolation, poor relationships with superiors, interpersonal conflict, lack of social support, harassment, bullying
Role in the organisation	Role ambiguity, role conflict, responsibility for people
Career development	Career stagnation and uncertainty, under or over promotion, poor pay, job insecurity, low social value of work
Home-work interface	Conflicting demands of work and home, low support at home, dual career problems

These hazards vary from workplace to workplace, but they also vary across time. New or emergent hazards may occur, and in recent years, issues such as harassment, violence and bullying at work have become more explicitly recognised as psychosocial hazards. The effect of the recession has also had an effect on emerging psychosocial hazards. Hazards of concern here include the threat of unemployment, a reduction in the quality of working conditions, and working in jobs where there is a misfit between the individual's capacities and the utilisation of their skills.

The European Survey of Enterprises on New & Emerging Risks (ESENER) (EU-OSHA, 2010) covered more than 28,000 enterprises in 31 countries across Europe. It points to many issues of relevance to the agricultural sector, but one of them pointed to the issue of information and competence to deal with psychosocial hazards. One finding was that despite work-related stress being reported as one of the key OSH concerns for European enterprises, only about half of them reported that they inform their employees about psychosocial risks and their effects on health and safety and less than a third had procedures in place to deal with work-related stress. The findings of the survey also showed that 42% of management representatives consider it more difficult to tackle psychosocial risks than other safety and health issues. The most important factors that make psychosocial risks particularly difficult to deal with were reported to be 'the sensitivity of the issue', 'lack of awareness', 'lack of resources' and 'lack of training'.

There is also evidence that there has been an increase in low paid, short term, precarious work (in part linked with the economic downturn) which has been a significant finding in relation to farm working. In effect, this is a reduction in the quality of work, and it compounds the sources of risk to mental health in the workplace. Furthermore, there is a lifecycle component to risks with some being more relevant at different lifecycle stages. These interactions between risks, lifecycle, income and social class means that more tailored interventions are needed that address mental health risks in all of their complexity.

12.6.2 Mental health risk assessment methodology

The PRIMA-EF initiative has developed a framework for risk assessment in relation to psychosocial hazards that is based on research and best practice from across Europe. It is a framework for undertaking risk assessment and management rather than a single, specific methodology – it is intended to accommodate variations in approach that are found in different countries while at the same time drawing attention to the essential elements of good practice.

Figure 3 outlines the main elements of psychosocial risk assessment. It is seen as being part of the overall management and organisation of work processes and being part of the production process within an enterprise. The risk management process begins with an audit and risk assessment of the psychosocial hazards within the workplace. Risks are then prioritised and translated into an action plan for interventions. Three levels of interventions are possible. The measures outlined within the risk management plan are then implemented and evaluated while the lessons from the evaluation process result in organisational learning which is fed back into the next cycle of the risk management process.

The implementation of the risk management process can be expected to have impacts beyond the confines of occupational health. As it addresses the primary production processes and the organisational context in which it takes place, it can be expected to impact on both individual and organisational outcomes such as health, productivity and quality, innovation and quality of work.

When undertaking a psychosocial risk assessment, a number of principles should be applied in order to increase its effectiveness. The principles outlined in the British Standards Institute guidance on managing psychosocial risks in the workplace (BSI, 2011) are presented below as an example of such principles.

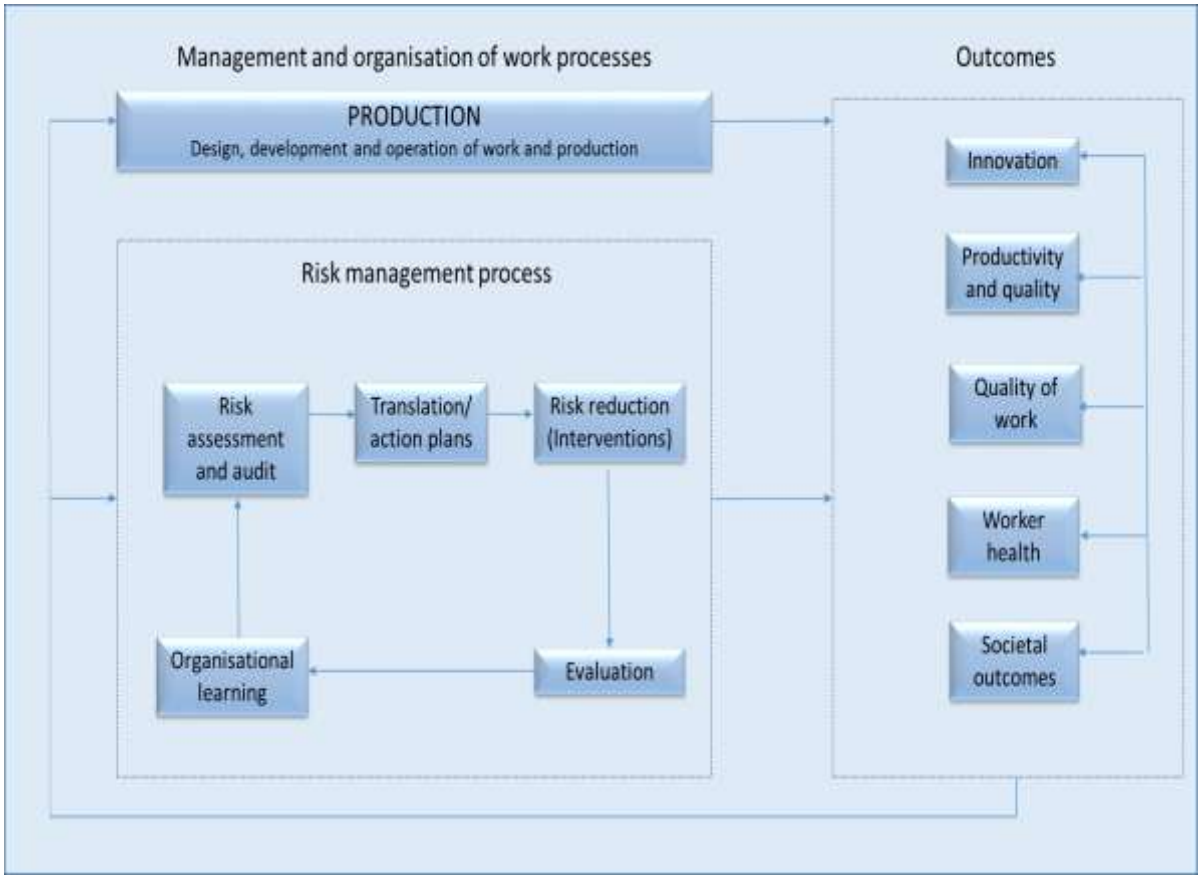

Figure 12-2 The framework model for the management of psychosocial risks (Source: PRIMA-EF project)

The UK Standard on risk management specifies a number of principles that should be applied when managing psychosocial risks:

- Work with defined groups
- Focus on working conditions, not individuals
- Focus on big issues
- Provide evidence of the effects of working conditions on health
- Use valid and reliable measures
- Ensure confidentiality of information
- Focus on risk removal or reduction
- Involve employees

12.6.3 Types and effectiveness of interventions

Wynne et al (2015) also address the types and effectiveness of risk assessment interventions. They state that being able to assess the risks associated with hazards is not an end in itself – it is the beginning of a process of controlling workplace hazards and risks. It is a means to identifying and prioritising these problems so that appropriate interventions can be made. It is best to prevent these hazards from occurring at source (primary interventions), but it may also be appropriate to implement secondary or tertiary level interventions.

There has been a large amount of research available on interventions to address psychosocial hazards in the workplace (this is summarised well in the PRIMA-EF publications and elsewhere). Three types of intervention are theoretically possible.

- Primary intervention is concerned with prevention and falls clearly within the tradition of OSH. It is not always possible, however, to prevent psychosocial risks at source – for example, long hours are

sometimes unavoidable in farming, while night working will always be needed where, for example, lambing season is taking place. On the other hand, work overload can be prevented in many situations. Examples of primary interventions include shift schedule design, workload management and improvement of the physical work environment.

- Secondary intervention is concerned with changing the way that workers perceive the psychosocial hazards and with improving their ability to cope with them. It often involves providing training and awareness raising and is one of the most common types of intervention. In relation to physical hazards, secondary interventions also encompass the use of personal protective equipment, but this type of intervention is difficult to apply in the case of wellbeing at work.
- Tertiary intervention involves of symptom mitigation or treatment. It is often a part of the process of rehabilitation and is therefore closely tied in with all return to work processes. Tertiary interventions include treatment for psychological symptoms such as burnout, depression or anxiety. It should also include measures that aid the employee to return to work in a safe and timely manner.

All three types of intervention are appropriate when managing psychosocial risks. Not all hazards can be prevented and the measures that might be needed when making primary interventions are often difficult to design and implement, even if they are required under OSH legislation. However, there are measures that can be taken to prevent mental health problems arising. Sources of stress can be reduced or diminished, work can be redesigned and reorganised or work schedules may be altered. Occupational physicians may be involved in these types of interventions to the extent that they have been trained to do so.

Secondary interventions are more common, are perceived to be easier to implement and have seen a larger amount of research being undertaken on their effectiveness. Raising awareness of psychosocial hazards, providing training to cope with specific hazards as well as general coping skills are all effective methods of secondary prevention. Developing support groups among workers are also an example of this kind of intervention, which is especially relevant to the agricultural sector.

There is no fixed role for occupational physicians in relation to secondary interventions, especially with regard to mental health issues. However, where physicians are competent, they may be involved in training workers in coping skills, for example.

Tertiary interventions are not usually carried out by workplace actors, but by treatment and rehabilitation agencies. These are usually undertaken by public health services of some kind, though private health services also play a role. In some countries health services internal to the enterprise may also be involved in treatment. Workplaces may play a role in the organisation of and liaison with these services – in effect, they provide or organise a disability management service. This is especially important in the context of recovery and return to work practices.

Occupational physicians however, play a role in liaising with the services that do provide tertiary services – typically they interact with them in relation to assessing fitness to work and the recommendation and monitoring of workplace adjustments to enable the worker to function safely and effectively.

The effectiveness of these interventions depends not only on the intervention itself, but also on the ways they are organised and the context in which they take place. Key issues here include:

- **Employee participation** – interventions ultimately affect employees most and they have the highest level of knowledge about their own jobs Involving employees in the design, implementation and evaluation of interventions will therefore improve their effectiveness and efficiency.
- **Evaluation and reassessment of interventions** – the design and implementation mental health related interventions needs tailoring to the circumstances of each workplace context. Evaluating interventions as they happen and reorienting them as required will ensure more effective interventions.
- **Ethics –** when dealing with mental health issues, ethics are especially important. Steps need to be taken to ensure confidentiality of information and that interventions are clearly targeted to benefit

employees as well as employers are needed. It should also be made clear that no harm can come to employees as a result of taking part in mental health related interventions.

12.6.4 Barriers to risk assessment

However, the difficulties of implementing comprehensive psychosocial risk assessment procedures in small enterprises and in farms should not be underestimated. There are often problems of lack of in-house expertise and of the resources needed to undertake the assessment. In these situations, easy to use tools, external (low cost or no cost) assistance and training are necessary if meaningful risk assessment is to take place. In addition, where there is only one person working on the farm, the implementation of both risk assessment and risk reduction measures are especially difficult, since the individual must fulfil the roles of both employer and employee – in effect they become the agent for and the target for change.

These issues are taken up again in the next Section which deals with the issue of making interventions in the area of mental health and wellbeing at work.

12.7 Interventions for mental health and wellbeing

Broadly speaking, the kinds of intervention to address mental health issues in the workplace that may be made can come from three areas - health and safety, workplace health promotion or return to work (Wynne et al, 2015). In their guidelines for employers on managing mental health issues at work, Wynne et al identify the commonalities and differences between the approaches needed to undertake activities of these three kinds – see Table 4 below.

Table 12-4 Types of interventions for addressing mental health at work

Activity	Occupational safety and health	Health promotion	Rehabilitation and Return to work
Information gathering and analysis	– Hazard identification – Risk analysis – Infrastructure assessment	– Needs analysis – Infrastructure assessment	– Absence analysis/ rehabilitation needs assessment – Infrastructure assessment
Interventions and methods	– Physical environment – Education and training – Work organisation – Job design – Protective equipment – Cultural change – Behaviour change	– Physical environment – Education and training – Work organisation – Job design – Cultural change – Behaviour change	– Case management – Rehabilitation – Capacity assessment – Physical environment – Education and training – Work organisation – Job design – Cultural change
Outcomes	– Reduced accidents – Reduced occupational illness – Lower stress – Better work practices	– Better quality work – Reduced absenteeism – Improved mental wellbeing – Better health – Faster return to work	

	– Improved work environment – Improved productivity – Reduced costs	– Retention of skilled employees – Better fit between the worker and the job

Adapted from Wynne et al (2015)

The aims of each of these approaches differ, but there is considerable overlap between them also:

- Occupational safety and health – this approach aims to prevent workplace risks to mental health and wellbeing or modify their impact
- Workplace health promotion – this approach aims to use the workplace as a setting to undertake interventions to improve mental health and wellbeing and to seek to accentuate the salutogenic elements of workplace
- Rehabilitation and return to work – this approach seeks to ensure the recovery of an individual who has had a mental health breakdown (whatever its cause) and to reintegrate them into the workplace in a safe and timely manner.

These three approaches use different tools and techniques which stem from diverse backgrounds such as medicine, engineering, psychology, social work, occupational therapy or physiotherapy. However, they also share a broad approach – each type of intervention undertakes a set of information gathering activities, the development of interventions that are based on the assessment of needs and the production of a desired set of outcomes.

All three approaches have an information gathering and analysis phase. Here the methods used tend to be specific to each approach – in the case of OSH it involves hazard identification and risk assessment (see previous chapter), in WHP it involves needs assessment, while in RTW it involves the analysis of absence management data and needs assessment. In addition, all three approaches share an 'infrastructure assessment' activity, which assess the knowledge, skills and capacities available either within or outside of the enterprise to carry out their functions.

The three approaches also share some common methods and interventions, i.e. the means by which they produce their intended outcomes. Common approaches include altering the physical and psychosocial environment through better job design, promoting an appropriate organisational culture change, improving work organisation and so on. However, there are also differences in the interventions that may be made. Health promotion interventions may targeted at general health issues (e.g. coping skills, attitude change, social support) as well as at workplace issues such as work schedule design, training for job skills or changing work cultures. Rehabilitation and RTW interventions also differ, especially early in the process. Essentially these involve case management (actively intervening early to help organise the services involved on treatment and rehabilitation; communications between the employer, the individual and services; the assessment of (residual) capacity to work upon return to work; making accommodations and adjustments to the physical and psychosocial workplace in order to facilitate return to work.

Finally, the outcomes of each of the approaches have much in common. They include reduced accidents and illnesses, better wellbeing and better health for the individual. On the organisational side, they include improved productivity, reduce absenteeism and the retention of skilled and valued employees.

Despite these differences, there is still a commonality in the approaches and methods, as well as in the personnel that might undertake these activities to warrant a common approach.

These interventions, while somewhat easier to implement in larger enterprises where there is a greater likelihood of in-house expertise being available, nevertheless are largely applicable to the smaller and one-person enterprises found in the agricultural sector. Occupational physicians from external services can have an obvious role to play in these activities for all three type of activity. For health and safety, they can play a

role in risk analysis and in the planning of appropriate interventions to control these risks. For health promotion, they can be involve in needs analysis and in the design and delivery of many interventions. For the RTW activity, they have an obvious role on the assessment of fitness to work and in the design of workplace accommodations. In addition, they can liaise with the external public health services that are involved in rehabilitation.

There are a wide range of tools and exercises available to support all three facets of workplace health interventions, though these are more commonly available for more traditional, physical health hazards and conditions than for mental health and wellbeing. Also, there are few if any tools and exercises that are specific to the agricultural sector. As a result, the practitioners are faced with having to adapt more generic tools for use in a sector such as agriculture. Nevertheless, there are still some widely used tools and some specific ones that can be used. Useful sources are outlined in Table 12.5 below.

Table 12-5 Useful tools and techniques to address mental health issues in the workplace

Activity	Source
Occupational safety and health	The COPSOQ questionnaire is a widely used tool for assessing psychosocial risks in the workplace. Available from: http://www.mentalhealthpromotion.net/?i=promenpol.en.toolkit.142 Others may be foiund on the ProMenPol website (described below).
Mental health promotion	The European Network for Mental Health Promotion oversaw a number of projects that are relevant to assessing mental health promotion needs. One site within the portal provides a tools database which can be searched for tools to support the assessment of health promotion needs (the ProMenPol project site). http://www.mentalhealthpromotion.net/?i=promenpol.en.toolkittab It also provides a manual for implementing mental health promotion at the workplace (MHP-Hands) and an online training resource on how to implement MHP in the workplace (MindHealth). http://www.mentalhealthpromotion.net/?i=handbook.en.e-handbooks-old http://www.mentalhealthpromotion.net/?i=training Examples of good practice in the area (as well as other tools) have been produced by the ENWHP. See: http://www.enwhp.org/enwhp-initiatives/8th-initiative-work-in-tune-with-life.html
Return to work	Tools that are specific to returning people with mental health problems to work are rare, but a number of good general approaches have been developed. The Canadian Institute for Work and Health website is especially good: http://www.iwh.on.ca/return-to-work-practices In addition, the ENWHP have a useful, set of tools and examples of how to deal with return to work issues for people with chronic illness (including mental health problems): http://www.enwhp.org/enwhp-initiatives/9th-initiative-ph-work.html

12.7.1 Tailoring interventions to the agricultural sector

There are a number of challenges to be faced when considering making interventions on mental health issues in the agriculture sector. Many of these relate to structural issues such as the issue of small size of farms and agriculture enterprises, but others relate to the cultural issues that operate within the sector. For example, issues concerning taboos about mental health issues, mistrust of people outside of the farming sector and others combine to make the delivery of workplace related mental health services more difficult.

A further factor concerns the structure and perceived role of occupational medical services – often they are small in size, independent operators that typically struggle to deliver services to very small enterprises. In addition, the issue of payment for services may arise. The challenges to be faced in the delivery of occupational medical services for mental health issues to farmers and rural areas are summarised in Figure 2 below.

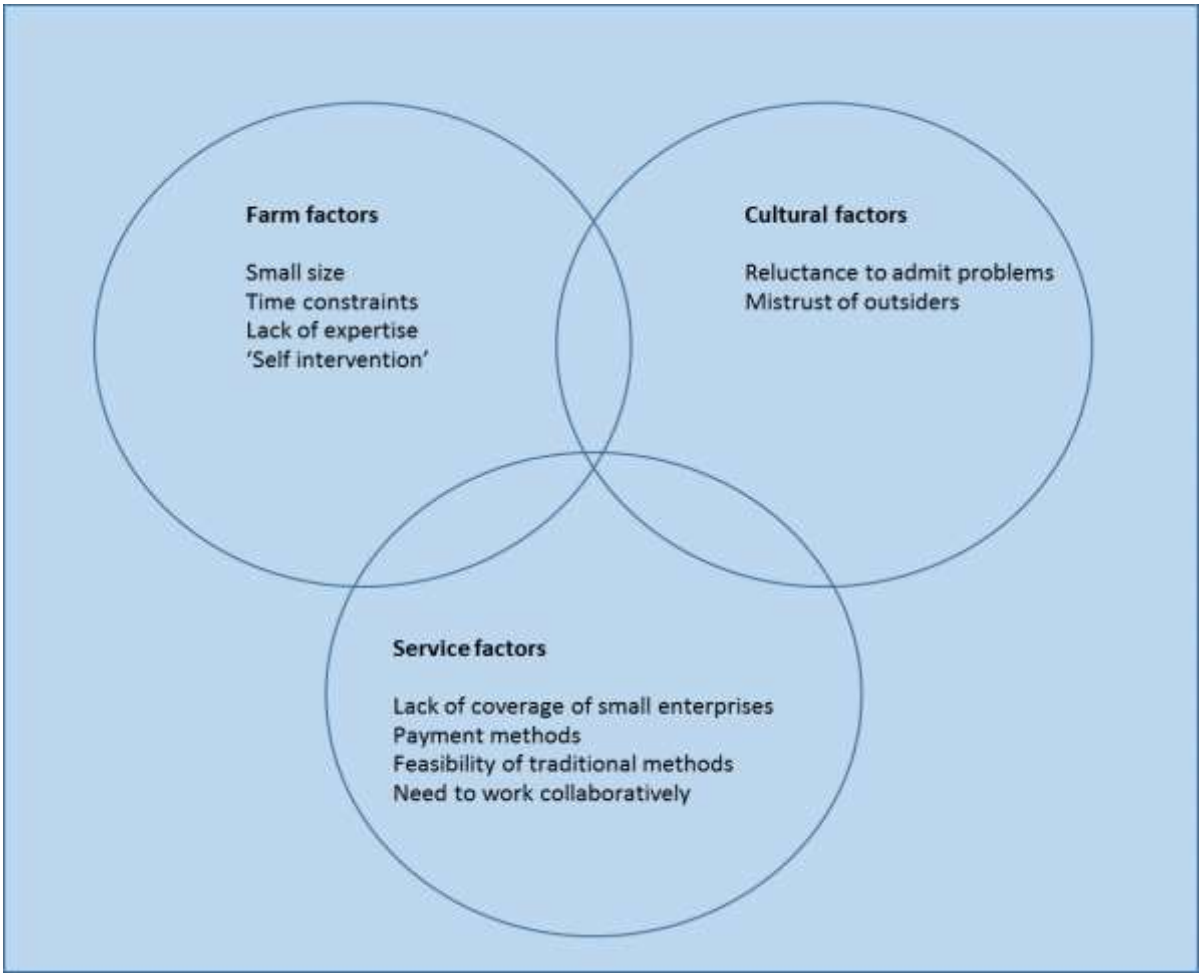

Figure 12-3 Constraints on the delivery of mental health services to small farms

The net effect of these constraints has typically been to reduce the involvement of occupational health services in mental health initiatives for farmers and their employees, yet there exist models within the sphere of public health that have successfully addressed mental health issues in the farming workplace, using a combination of health promotion and other interventions. Recent examples of this can be found in Finland, New Zealand, Australia and Ireland. These are briefly outlined in the boxes below.

In the Finnish case, the availability of a tailored and comprehensive occupational health service is perhaps unique in Europe. However, it demonstrates what is possible with appropriate organisation. One of the

striking features of this service is that it deals not only with closely defined occupational risks, but also extends the service to include more general health issues (through annual medicals) and the farm families as well.

Example 1. Finland: farm occupational health services

Finland has a comprehensive occupational health system that consistently covers about 90% of the national workforce (WHO, 2012). For farmers and agricultural workers (and related sectors such as forestry), occupational health services may be delivered through a network of 31 municipal health centres which comprise a range of occupational health related professionals.

The services provided entitle members to an annual health check, farm visits by specialised nurses who assist in hazard identification and risk assessment. The service addresses family health needs also.

The scheme is funded through the Farmers Social Insurance Institution (MELA: https://www.mela.fi/en/about-mela) which part covers the costs of services (the remainder is covered by the State) and about 60% of Finnish farmers who work full time are involved in the scheme.

Amongst the other activities of the MELA organisation is the co-ordination of a farmer's holiday scheme, whereby farmers are enabled, free of charge, to take a holiday by other farmers who are paid for their labour (https://www.mela.fi/en/farmers-holiday-and-stand-scheme). This scheme also entitles them to sick leave support as well.

Example 2. New Zealand: The Psa kiwi fruit crisis

In 2010 a major disease outbreak in kiwi fruit (the Psa bacteria) affected the Bay of Plenty region in New Zealand. Many farmers were facing severe financial impacts on their business and the knock-on effects of the outbreak on farm related industries was also set to be severe.

The impacts on farmers and their families was also expected to be severe in terms of the mental health and wellbeing. It was also realised that interventions must be made if lasting and severe mental health problems were to be avoided.

The local stakeholders within the industry and public health authorities came together to develop a programme that involved:

- Taking an inclusive approach – the problems of the disease outbreak were not owned by any individual but by the community as a whole
- The initiative was led by people from within the farming community
- Meetings and seminars were held throughout the region which openly discussed the mental health issues that arose. A clinical psychologist supported the community leaders with expert support
- Practical support was made available in the areas of financial, operational and psychological issues – many people were trained in suicide prevention skills
- Interventions were taken out of the service suppliers offices and brought into community settings that farmers felt comfortable in
- Coping skills training sessions were held
- Mostly funded by the industry, not by Government

The target for the programme was set that no farmer should commit suicide as a result of the disease outbreak - none did.

Adapted from Naik, (2016).

This example from New Zealand provides an interesting example of how industry, public health and the community came together to create a practical and locally based response to a set of events that could easily have had a major impact on mental health and wellbeing. It shows the benefits of being practical, of using champions from within the community and of collaborating with the major players when constructing a proactive programme. One groups seemed to be conspicuously absent – occupational physicians. The question may be asked as to why this was the case. It may be that they were not present in the sector or did not have the capacity to respond, but it would seem that the disease outbreak posed a real risk to mental health and wellbeing that could have been predicted and mitigated by appropriate OSH measures.

Example 3. Ireland. The Farm Safety Initiative – a collaborative approach to mental health issues among farmers

The Farm Safety Partnership (see Chapter 4 for more detail) addresses both safety issues and the wellbeing of farmers in Ireland. It is organised in a top-down manner by the national agency the Health and Safety Authority (HSA), but involves a wide range of stakeholders from the state, private, social partner and community sectors. Acting from national to community level, it undertakes a wide range of activities such as inspections, training, and the provision of advice, events and demonstrations.

One of its 6 strategic goals is concerned with improving the health and wellbeing of farmers, specifically 'to implement programmes for the protection of health and wellbeing of persons, including vulnerable groups, working in agriculture'. The actions relevant to mental wellbeing in this area include:

- Raising awareness of the health issues currently affecting farming
- Monitoring health status of those working in the sector
- Improving farmer knowledge of health
- Promoting stress management among farmers

While the HSA has overall responsibility for implementing the plan of action, implementing these actions has meant taking a collaborative approach, as no single agency has the capacity, reach or credibility to do so on their own. In practice there is a single or small number of organisations with responsibility for leading and organising the actions and in the case of the health and wellbeing strategic goal, responsibility lies with the FBD insurance company and the Faculty of Agriculture in University College Dublin. These are supported by a full range of other rural and health and safety stakeholders, including:

- State Agencies
  - The Health and Safety Authority
  - Teagasc (the State farm advisory organisation)
  - The Health Services Executive
  - Ministry of Agriculture
- Representative bodies
  - The Agricultural Consultants Association
  - Farmers representative bodies
- Professional bodies
  - The Institute for Occupational Health and Safety
  - The Veterinary Council of Ireland
  - Veterinary Ireland
- Others

Taken from: HSA (2015)

There are a number of lessons to be learned from these examples:

- The role of collaboration: addressing mental health issues for a group such as farmers needs a collaborative approach – individual organisations generally do not have the reach into farms, the credibility amongst farmers or the capacity in terms of personnel to mount an effective response on their own.
- Addressing both public and occupational mental health issues: the more successful initiatives involve elements of both occupational health and public health. In the case of farming, the causes of mental health problems do not solely emanate from the workplace – an approach which integrates these two approaches is more likely to be successful.

The need to involve the farm sector: given that the taboos that are attached to the mental health are especially strong in the farm sector, it is essential that any initiatives to address mental health issues involve farmers themselves in a lead role. These are the group with the highest levels of credibility amongst their peers and are therefore likely to lead to a higher take-up of the initiative.

12.8 Conclusions

There are a range of conclusions that can be drawn from this examination of mental health and wellbeing issues in the farming sector. These are proposed in light of the special context of farming (small numbers of employees, often solitary working, farm business pressures, integration of the workplace and the home), which make it an especially difficult workplace to address with traditional health and safety measures.

Mental health is a significant issue in the agricultural sector in terms of both its prevalence and cost. Though there is not a very large body of evidence, there is ample data from a number of countries to suggest that farming is at least as high risk an occupation as any other.

The need for new approaches and partnerships - given the uniqueness of the farming context, new partnerships between occupational health, public health and the non-health community sector offer the best prospects for addressing mental health and wellbeing issues systematically.

The shared characteristics of methods across workplace approaches – at the workplace level, the approaches that may be used to address mental health issues share methods that can be integrated, for example, risk assessment for health and safety and needs assessment for health promotion methods have common features. This helps with integration of approaches as well as reducing the effort needed to implement both approaches.

New tools for managing mental health and wellbeing in the agricultural sector – there is a need to develop new tools for both risk assessment and intervention to deal with the mental health problems that farmers and others experience. These tools will need to be able to deal with both occupational and non-occupational risks, to be able to intervene using methods from both occupational and public health, and are likely to involve using group based methods (rather than methods that focus on a single enterprise).

The role of OSH services – mental health issues challenge OSH services in a number of ways. They do not fit the classical disease model of ill health and so demand a different set of interventions than might be the case for infectious disease, for example. In the agricultural sector, additional demands arise from the fragmented and small size of agricultural enterprises, the lack of internal resources available to most of these enterprises and the lack of reach of many OSH services to the sector. Fo0r OSH services to be effective, models of implementation that involve working with and through other agencies need to be developed.

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