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Managing company responsibility for mental health in the New Zealand construction industry

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Abstract

Health and safety in the construction industry has traditionally had a strong emphasis on safety, with the health aspect receiving little attention beyond high profile issues related to asbestos and silica. More recently, however, studies and initiatives in several countries have identified the mental health of construction workers as an area that warrants greater attention. In New Zealand, new legislation on workplace health and safety which was implemented in 2016 explicitly includes non-physical harms in its scope, so employers are required to consider the mental health of their workers as part of providing a safe workplace. This paper provides a cross-case comparison of mental health awareness and initiatives in two New Zealand construction companies. The first company is a Tier 1 management-only main contractor, while the second is a Tier 2 company which is involved in full construction activities and operates both as a main contractor and sub-contractor. The health and safety policies and procedures of both companies were analyzed, and a range of company representatives were interviewed including human resources managers, health and safety managers, office and site staff. Managers and staff at both case study companies expressed varying degrees of understanding of company obligations under the legislation and considered it difficult to take practical steps to fulfil their responsibilities. The Tier 2 company in particular struggled with identifying and managing the needs of the wide range of employees represented. The shared responsibility between human resources and health and safety representatives was seen as a complicating factor for both companies. Despite the challenges, the case studies offered insights into potential best practice in the area, and recommendations are provided for improving performance in workplace mental health in construction.

Keywords: workplace mental health, worker wellbeing, health and safety policies

1. Introduction

The construction industry has long had a reputation for poor workplace health and safety (H&S), and construction-related roles continue to rank highly on lists of dangerous occupations. However, world-wide drives in the past decade have resulted in significant progress in improving construction safety, in terms of both raising awareness of the importance of H&S to industry participants, and reducing the number of workplace-related incidents. Health factors overall have received less attention and mental health in particular has long been the 'poor cousin' to physical H&S, but there is growing attention to this aspect of workplace H&S. The construction industry has one of the highest occupation suicide rates, as well as non-fatal suicidal behavior at rates above those of the population average (Milner et al, 2015). These are extreme symptoms of a range of mental health conditions which are present in construction workers, including the common mental disorders of anxiety, depression and stress. At a company level, higher sick leave and absenteeism result, as well as presenteeism where people continue working despite being unfit to do so, all of which have costs to productivity and workplace engagement. In a larger context, these result in monetary costs to society as well as social impact (Kinchin & Doran 2017).

The construction industry is notoriously conservative, male-dominated, and emphasizes performance under pressure. Construction has been characterized as an 'extreme job', with professionals and managers working exceptionally long hours in demanding roles. One of the central drivers of this environment is a culture described as competitive masculinity, which "enables men to enact a traditional masculine identity through competitive tests of physical endurance, stamina and sleeplessness" (Gasgoine et al. 2015: 462). Such an environment contributes significantly to an unwillingness to address mental health issues at both a personal and organizational level. However, recent legislative changes in several countries surrounding mental health monitoring and assistance in the workplace (McDaid et al. 2017) has ensured a wider conversation around workplace mental health is now taking place and continuing to develop in prominence.

Many organizations in the construction industry have introduced initiatives and actions to meet the requirements of legislation, and to address the potential needs of their employees. The majority of initiatives for mental health in the construction industry are intended to provide assistance for workers, and are led by charities or government groups. Initiatives aimed specifically at the construction industry in Australia include MATES in Construction, which focuses largely on suicide prevention (MATES in Construction 2016), and Incolink, which provides support for construction workers struggling with redundancy (Incolink 2018). "Contact & connect" (Milner et al. 2015) is another Australian initiative trialled on construction workers, which sought to educate participants about depression symptoms as a means of reducing the stigma associated with depression. In the United Kingdom, Mates in Mind focuses on working with employers to improve workers' awareness and response to mental health issues (Mates in Mind 2017). In New Zealand, there are currently no initiatives aimed specifically at the construction industry. Sitesafe, the construction industry H&S organization, currently focuses almost exclusively on physical aspects of H&S.

The most common focus of mental health initiatives is to increase awareness and knowledge of the issue of mental health, introspection, identifying what help is available and reducing stigma. MIC includes training aimed at increasing awareness of mental health throughout the construction industry and providing workers with guidance as to how they can help themselves and others. MIC training sessions are delivered on sites to the majority of the workers on site and are across Australia (MATES in Construction 2016). MIC also provides specialized 'connector' training in mental health, over and above general education. This is modelled along similar lines to construction site first aider requirements, where sites are currently required to have a specific minimum number of first aid trained workers, based on how many workers are on site. Each site MIC is engaged with has workers with 'connector' training, again dictated by the size of the site but currently limited by the number of volunteers available. The training provided to 'connectors' helps them to be aware of warning signs of suicidality, and teaches them engagement and intervention techniques, as well making them aware of additional assistance available to themselves and their peers (Gullestrup et al. 2011).

Another approach to mental health support in construction is the development of guidelines for construction companies that help them develop procedures for mental health that are in keeping with both legal requirements and the industry standard. The Australian Institute of Building (AIB) has a 'mental health in the construction industry' policy position document that outlines good practice around mental health in construction organizations. Advice suggests companies should encourage workers to seek help, simplify the process of asking for and receiving help, discourage substance abuse, and de-stigmatize mental health and wellbeing issues (Australian Institute of Building 2013). While this document does not provide a template for companies to use, it does highlight what their main industry body broadly believes they should be doing to help address the issue. New Zealand's official H&S regulator, WorkSafe, has its own expectations of what systems employers should have in place. These expectations provide a snapshot to employers of their legal requirements such as health promotion to combat noise, work demands, fatigue and chemicals etc., but also recommends actions to support worker well-being more broadly, such as bullying prevention, fatigue management, and promotion of quality work relationships, that all affect mental health at work.

The intention or focus of mental health initiatives can be categorized in terms of primary, secondary or tertiary level outcomes (LaMontagne et al. 2014). At the primary level are work-directed initiatives, which focus on the causes and catalysts of poor mental health and aim to reduce workers' exposure to job stressors that are known to cause poor mental health. Primary initiatives in the construction industry appear uncommon, with the literature in this area mainly seeking to identify the job stressors that may have a negative effect on mental health. Beyond that, there has been some limited research into steps that can be taken to alleviate these job stressors, including a case study by Lingard et al. (2007) on the effect of different work-hours schedules on the wellbeing of the workers. Secondary level initiatives appear much more common, with a focus on changing workers' response to mental health challenges, particularly though increased awareness and self-management, rather than changing the nature of the work. Examples are education and training initiatives such as MIC's General Awareness Training (Milner et al. 2015), Mates in Mind's partnership with Mental Health First Aid England (Mates in Mind 2017) and the AIB's support and advocacy of suicide awareness and organizations that promote mental health literacy (Australian Institute of Building 2013). Tertiary initiatives focus on intervention and provision of assistance to workers who are suffering from existing poor mental health or who have developed mental health disorders as a result of work or personal stressors. Tertiary interventions tend to be more difficult for employers to manage directly than primary and secondary level interventions, and there is currently little evidence that they have an impact on work-related outcomes such as absenteeism and presenteeism, largely because follow-up support for affected employees is not well-managed or monitored (Joyce et al. 2015).

All three intervention types are complementary to each other and initiatives often have a combined focus, most commonly connecting secondary and tertiary level delivery together. However, tertiary interventions may require more individualized attention to achieve effectiveness in the workplace, while secondary interventions tend to be education and training initiatives aimed at increasing mental health literacy, rather than directly affecting behavior. Primary level interventions appear to be less common than secondary and tertiary, but show promise of being very effective.

2. Methodology

Two New Zealand construction companies were selected for study to provide a preliminary understanding of how the New Zealand construction industry is dealing with workplace mental health. Both companies are medium-large enterprises, with differences in several key aspects, as identified in Table 1. They were chosen based on the assumption that medium-to-large companies will be at the forefront of change in this area. Small companies are unlikely be going any further than their larger counterparts, due to a lack of resources and limitations in organizational roles and skill-sets that do not encompass specialist HR and H&S staff. The research strategy used is multiple case study using a cross case analysis (Yin 2003), directly comparing results from the two cases investigated.

Table 1: Different characteristics of chosen companies.

Company A	Company B
Tier 1	Tier 2
Publicly listed company	Family owned and operated company
Operating nationally in New Zealand	Based in Auckland and operating in main urban centres of Christchurch, Hamilton, Tauranga, Queenstown & Wanaka
Always main contractor	Acts as main contractor or subcontractor
Only directly employs management, subcontracts all trades	Employs both workers and managers, subcontracts many trades but self-performs some trades
Reducing in size and scope	Expanding in size and scope

A cross-case approach, while unable to represent the sector as a whole, provides a useful illustration of contrasts or similarities in the direction taken by companies of this size, and offers potential insights into challenges, necessary improvements and directions for best practice. Within the case study methodology, semi-structured interviews and document analysis have been used to collect data. Documents analyzed included written company policies, guidelines, company directives or any education material provided to the employees by the company, regarding mental health. Company policies are the agreed 'code of conduct' between a company and its employees, protecting the interest of both the company and the employees, whereas verbal accounts of what assistance a company offers their employees offer valuable information regarding how closely the companies follow their own guidelines and how their actions are perceived. Selection of interviewees from each company was based on the position they held within the company. For each company, one person in each of the following roles was interviewed:

- *Health and safety representative (H&S Manager)*: The H&S officers of a company have a responsibility for managing the mental health of workers under HSWA 2015.
- *Human Resources representative (HR Manager)*: Staffing issues are traditionally the responsibility of a company's human resources department, including managing aspects of workers' metal health.
- *Project Team representative (Project Manager)*: Project teams lead the workforce, spend the most time with the workers, and work similar hours. The project team is also the main link between workers and the wider company, so their knowledge and perception of their company's mental health assistance is critical to understanding how appropriate the assistance is, and to help ensure that workers get the attention and support they need.
- *Worker representative (Worker/Foreman)*: Workers and their supervisors are the group identified internationally with one of the highest occupational suicide rates. Their knowledge and perception of their company's mental health support is crucial to understanding how appropriate the support is.

The role described in brackets in each indicates how that participant has been referred to for the purposes of this report, and does not necessarily represent their job title.

3. Findings – Company A

Company A participants had mixed views on the company culture regarding mental health. Two considered that the company does not treat the issue with the priority it should, and two felt that it is taken "pretty seriously." When asked whether the traditional stereotype existed of struggling workers being told to 'harden up' by their colleagues or managers, the majority did not believe that that culture was still prevalent. The Worker/Foreman and the Project Manager both felt that this approach had previously existed but that the culture had moved on, "23 years ago when I first started it was all 'I'm a hard man, I'm in construction…', but now it is not like that" (Company A, Project Manager). However, the HR Manager argued that there is still an element of that stereotype present in the company, "there is [the attitude] 'just take a concrete pill and get over yourself," and suggested that many in the company, from senior management through to project personnel, have not changed their thinking. The HR manager has worked in the construction industry for a comparatively short period, so their more critical view may be a result of not having experience of how far the culture has progressed, but may also provide an indication of how construction industry attitudes compare to other sectors.

All the Company A participants believed that their company's efforts in managing the mental health of workers would be below international standard, although only one participant based this opinion on their own overseas experience. The Project Manager suggested that the New Zealand industry was less advanced than international practice across the board, rather than for mental health management in particular, "we are little New Zealand, and industry-wide we are always just a little bit behind the 8 ball." Participants all considered that Company A was setting the standard or was on par with the rest of the New Zealand construction industry; "I would think if we weren't doing something or didn't have it out there, other companies would be similar to us if not worse" (Company A, HR Manager).

Despite considering their company to be an example of New Zealand best practice in the area of mental health, participants' knowledge or awareness of measures that Company A was taking was limited. All participants from Company A said they weren't sure of any formal mental health policies or procedures put in place by the company. Part of this lack of knowledge appeared to stem from changes within the company. Up until recently Company A was reported to have a rehabilitation department that had the responsibility of looking after mental health. With the recent reduction in company size, however, it appears that their roles were disestablished and not replaced. The HR manager noted that, "actually there has been a bit of a void for the last probably 12 months in that space." Further discussion identified that the company does have a number of measures in place, although participants were unsure whether they were formal company-based initiatives or informal activities supported by different groups.

The main primary or work-directed initiative evident in the company was monitoring of worker hours, seen by all participants as contributing to the management of mental health. The company uses an electronic sign in and out system which is downloaded weekly; the main purpose is workforce and payroll management, but the system is also used to monitor hours and make sure that individuals who have worked over the threshold are given compulsory paid leave. Fatigue and expectations of long work hours are widely recognised as a contributor to poor mental health, so attention to this issue is a significant primary level intervention that helps to change the nature of the work.

An informal measure identified by the H&S Manager was that the company had sought to increase the ratio of women in the H&S team, in an effort to appear less confrontational and easier to deal with: "Our safety team now is 50% men and 50% women because the guys out there will speak more openly to a female." This may be considered a primary level initiative, as it is intended to change the culture of workplace relationships and thus reduce workers' exposure to conflict as a job stressor.

A significant secondary initiative described by the HR Manager is a programme that is currently in the planning stage at Company A, to use high-profile personalities who are well-known mental health activists and promotors. The rationale behind this strategy is to promote the issue using widely-respected outsiders that workers can identify with and trust, rather than to use senior management who may be seen as having other motives. In addition, mental health first-aid training awareness was being implemented for the H&S team. These approaches provide worker-focused interventions that seek to make workers more aware of their own mental health and that of others they work with.

One of the most widely known measures to counteract strain on mental health that Company A has implemented is the use of an external third-party Employee Assistance Programme (EAP), should an employee require assistance the company cannot easily provide. This programme provides access to a network of professionals to support a large variety of causes and effects of poor mental health. Such a service can be considered mainly a tertiary intervention, as it provides help to workers who are experiencing difficulty. The three management-level participants all recognised the company's use of EAP in managing mental health, but the Worker/Foreman did not mention it, which may indicate that the service was not advertised enough or was not brought to the notice of workers on site. Other measures mentioned by participants included yearly health checks including questions relating to hours worked, stress levels and other related aspects of the role; mental health first-aid training awareness for the health & safety team, and occasional days off or flexible weekend rosters if a person is identified to be overworked or stressed.

Company A provided nine documents that were considered most relevant to mental health management in the company, as listed in Table 2. These documents are all stored on Company A's database, which employees are taught how to use during their company induction, making them easily accessible to Company A employees. However, analysis showed that very few of these documents contained information or guidance relevant to mental health management. The Health and Safety Manual is the most relevant document, and includes company-specific initiatives that were identified by participants in the interviews, such as a formal health monitoring process and the engagement of EAP Services. The

Manual includes further mental health-related initiatives that participants did not identify, including support and rehabilitation of employees with drug and alcohol problems, and a voluntary annual health promotion & wellness programme that targets health needs and demographics of its workers. None of the documents contains any mention of a cap on hours worked, despite that being described by participants as the most significant mental health measure in place in the company.

Table 2: Documents submitted for analysis by Company A

Document	Author	Pages	Status/Relevance
Health and Safety Manual	Company A	110	Key company document, 1.5 pages relevant to mental health
Environmental Policy	Company A	1	Key company document, not relevant
Quality Policy	Company A	1	Key company document, not relevant
Sustainability Policy	Company A	1	Key company document, not relevant
Workplace Health policy	Company A	1	Key company document, 1 relevant sentence
Safety Management Plan Template	Company A	36	Key company document, 1 relevant sentence
Healthy Work - Managing stress and fatigue in the workplace	OSH, NZ Department of Labour	79	Published 2003; no reference to this guideline is contained in any of the other documentation.
Helping a workmate with anxiety	Healthworks	1	Poster from an Australian workplace health provider; not circulated or displayed.

Two of the provided documents were publications from external organisations, that appeared to have been filed for reference but were not actually in use within the company. In the interviews, the Project Manager noted how difficult it was to find clear, concise and relevant information due to the quantity of information available and poor management of superseded documents, "policies get reviewed and renewed but the old ones do not necessarily slide out." The inclusion of external, out of date documents amongst company-specific policies and procedures only adds to this confusion.

Overall, the documents gave the impression that although Company A is aware of its obligations regarding mental health, the quantity of relevant material is lacking. This mirrors the message from the participants, who all believed the issue was serious, but had limited knowledge. The implication is that safety and physical health are still very much the focus, and mental health remains under-represented.

4. Findings – Company B

Company B's participants all believed that the company takes mental health very seriously as a whole. However, the H&S Manager considered this awareness to be limited to management level: "company directors take it very serious, whereas the man on the ground does not understand it yet". The H&S Manager also felt that the 'just harden up' culture was still prevalent within Company B. The other participants however, felt that attitude was not only absent from Company B but was no longer present in the industry: "I think definitely over the last 10 years within the industry that culture is slowly withering away" (Company B, Project Manager).

Participants were unclear about who has responsibility for managing issues related to mental health. The HR Manager felt that although it was not necessarily their responsibility, HR mainly dealt with any mental health issues, "Health & Safety probably pass it over to us, to be honest with you." The H&S Manager believed that it was a joint effort between HR and H&S. The Worker/Foreman was unsure of where formal responsibility lay, but suggested that if issues arose, site staff would be more likely to speak to the H&S team. Further discussion suggested that the HR team dealt with individuals regarding any mental health issues that were brought to their attention, while the H&S team provided information on company requirements and the avenues of assistance that were available to workers.

Two of the participants considered that Company B's approach to mental health was at or above international construction industry benchmarks. This belief appeared to be based on loyalty to the company, rather than actual knowledge of international practice: "our employers are very good people and they have the welfare of their workers at heart, we are not just numbers, I firmly believe that" (Company B, Worker/Foreman). Similarly, all participants thought that Company B's efforts are at or above the New Zealand construction industry standard. However, the participants had limited knowledge or awareness of any formal or informal policies or measures that Company B had regarding mental health, with the HR manager having to refer to company documents to identify any company measures: "I am just having a look, I don't personally know of actual formal mental health policies." Further prompting revealed awareness of a range of initiatives that the company supports, but that were not immediately associated with mental health management.

The most widely recognised measures taken by Company B matched the responses from Company A. Foremost was the tertiary initiative of providing third-party support through EAP. The participants appeared to contradict each other regarding when Company B made this service available, whether some years ago, "we have access to EAP, which the company initiated 4-5 years ago", or more recently "about two years ago when EAP became part of the system", with the Worker/Foreman acknowledging that they were only recently aware of it "I have only been aware (…) over the last 3-4 months." This confusion can be attributed to a lack of advertisement; as identified by the HR Manager "it is not something that we are constantly promoting or pushing."

The other widely recognised initiative is the primary measure of monitoring of hours worked on site by workers and site management. A weekly report is sent to HR from the payroll department, highlighting employees who have clocked in over 54.5 hours the previous week. HR then use this data to discuss with project management and the construction directors about reducing the load on the current site teams regularly working over the threshold. The HR Manager identified that the high hours report is in response to HSWA 2015, commenting that "in legislation at the moment there has been a huge amount of push around people with fatigue."

Participants also identified measures that were under development such as an educational programme, for which the H&S Manager noted "We are currently busy working with the lawyers getting the correct wording on how to make sure we don't give ill advice." The HR Manager described a wellness programme that was to be rolled out with support from EAP Services. Other measures mentioned were far more informal, such as simply an 'open door policy' on the part of site managers to "ensure that they are coping with their workload, just discussions, personal life, is everything happy, just chatting with the guys really" (Company B, Project Manager).

In general, participants were aware that the company had obligations regarding the mental health of employees, but had very little clear recognition of their own responsibilities or of company-level measures developed in response to the legislation. Much of the discussion regarding initiatives in Company B was focused on the participant's personal understanding or activities around supporting staff, rather than on company policy or formal initiatives.

Company B did not supply a set of documents as was the case with Company A; instead, access was provided to Company B's intranet to allow identification of appropriate documents. Selection of the documents was based on a quick scan of document names and associated information in the intranet, rather than any in-depth reading of each document, to simulate how an employee would find the information they require. From this process, 11 documents were selected that appeared to contain relevant information, as listed in Table 3. Seven of the documents were selected from the Health & Safety section and four documents from the operations manual. Company B employees who have a company login are shown the intranet during their company induction, but because Company B employs both management and workers, not all employees have access to the intranet.

The documents are strongly safety-focused. Company B's "safety first" philosophy is highlighted throughout the company documents, while 'health' is seldom mentioned apart from the standard phrase "Health & Safety Environmental". There is no mention of any threshold or monitoring of hours or of the engagement of EAP Services, although the HSE Charter states that "rehabilitation plans should include counselling and assistance for families where appropriate". The almost complete exclusion of mental health from Company B's policy and procedures is surprising, considering the interview responses where all participants were adamant that the company took mental health extremely seriously.

Table 3 Documents collected for analysis from Company B

Document	Author	Pages	Status/Relevance
Quality, H&S & Environmental Systems Overview	Company B	2	Key company document, one relevant section
Health & Safety Policy	Company B	1	Key company document, not relevant
HSE Charter	Company B	12	Key company document, one relevant sentence
Site Specific Safety Plan (SSSP) Template	Company B	41	Key company document, one relevant sentence
Healthy Work - Managing stress and fatigue in the workplace	OSH	79	Published 2003; no reference to this guideline is contained in any of the other documentation.
Employee Assistance Programme	EAP Services	1	Summary of services for EAP; circulation unknown
EAP Services 2016 New Year Resolutions	EAP Services	5 x 2pp	Five e-newsletters containing information and advice from EAP; circulation unknown

As seen with Company A, documents from external organizations were included in the intranet alongside the company's own policy documents. These were copies of old information and advisory newsletters that had simply been saved to file, but had no relevance to the other documents they were stored with and nothing to indicate who or what they were intended for.

5. Discussion

The Health and Safety at Work Act 2015 (HSWA 2015) has explicitly incorporated mental health into the definition of overall health, and included the actions of a person resulting from their mental health in the definition of 'hazard' (HSWA 2015: s16). The HSWA also requires New Zealand companies to monitor the health of their employees (HSWA 2015: s36). Only one participant from each company expressed awareness of legal obligations regarding mental health, and both of these individuals believed their companies had not only met but exceeded the legal requirement. Despite detailing the requirements that companies must meet, HSWA 2015 provides no guidance on how companies are to comply, leaving it up to each company to develop procedures that fit within existing systems and to demonstrate that their procedures meet appropriate standards (Peace et al. 2017). Consequently, the two companies' perceptions of what was sufficient to comply with the requirements showed considerable difference in the level of documentation and support provided.

Education and training activities were being undertaken in both companies to some degree, and the need for more awareness was highlighted as a problem that both companies faced, particularly at the site level. This is mirrored internationally, as education for increased mental health literacy is one of the main initiatives found within organisations such as MATES in Construction (MIC 2016). The New Zealand construction industry health and safety organization, Sitesafe, currently does not partner with any workplace wellness and assistance services, nor does it provide general mental health training. As a result, each company has its own approach to training and education and different standards apply in companies with different needs and levels of engagement within the industry.

As seen throughout literature, the measures identified by the participants were mainly secondary or tertiary interventions, with the main primary intervention being the monitoring of hours. It seems that monitoring of the number of hours worked on site may be used as a crutch to prove they are making the effort to reduce fatigue. While this can be used to help satisfy the company's legal requirements, it indicates that they are still not "understanding the whole person and not just the person that is at work" as articulated by a participant from Company A. This is despite the requirement being identified and explained in detail in *Healthy work, managing stress and fatigue in the workplace* (Department of Labour 2003), a document included by both companies. This gives the impression that those within companies tasked with ensuring that legislation is complied with are saving guidelines to their database without notifying others of what the guidelines advise, nor incorporating the advice into their systems.

Sociocultural, economic and organisational barriers to progress in mental health management are evident in both companies, suggesting more systemic issues in the wider industry. The majority of participants were not sure of any measure intended to support mental health in their company, showing a lack of understanding of the causes of poor mental health and therefore a limited understanding of the issue in the industry. In particular, knowledge was seen to be lacking at the site level, "I think some of the site guys probably have less of an understanding of what mental health actually is, where the Health & Safety guys and us at senior management level have a reasonable understanding of what it is" (Company A, Project Manager). This seems to be an issue internationally, given the focus on educating site workers in initiatives such as MIC in Australia and Mates in Mind in the UK.

With the recent construction boom in New Zealand, the skills shortage is creating high demand for experienced and competent workers, who are therefore given more work to do. One participant articulated the effect of this, "the more skilled end up doing more work…that's when the mental health will come in…the stress of trying to do more work" (Company A, Foreman/Worker). This contrasts with the observations of LaMontagne et al. (2014) who identified that job stress in the construction industry tends to be perceived as individual weakness. The view that job stress may result from an unrealistic workload indicates potential willingness to address some of the systemic factors leading to mental health issues in construction. Only two participants believed there was still a 'just harden up' culture within their company or the wider industry, which further suggests that change is taking place.

Although the most widely mentioned measure for mental health management was the use of EAP services, the Worker/Foreman for Company A did not mention EAP, and the Worker/Foreman for Company B admitted that he had only recently been made aware of its existence. The HR Manager from Company B also commented that "not everybody who hasn't actually used EAP knows what they are all about." This suggests that the information is not available to those based on site, whether in the site office or out on the tools. An uncoordinated approach to the issue may be preventing information from being circulated effectively, with unclear division of responsibility between HR and H&S departments. Although procedures and assistance are covered within the companies' inductions provided to new employees, long-standing employees may be unaware of new measures that have been implemented. This problem is compounded by the lack of clarity in how relevant documents are managed, and the inclusion of irrelevant or out-dated documents alongside current information.

6. Conclusions and recommendations

This investigation of two companies provides a snapshot of the current approach taken by medium to large New Zealand construction companies to address the issue of poor mental health within the industry. Barriers displayed internationally, such as education issues, are seen to be common within the New Zealand industry, but a perception that the 'just harden up' culture has become much less prevalent indicates that the industry is ready to take the issue seriously and implement counteractive measures.

Several recommendations can be made, based on the findings of this study. Education needs to be conducted both from the top down and from the bottom up to ensure that all employees are receiving

clear, relevant information. A nationwide education drive to senior management of construction companies would serve to raise the profile of mental health issues, and would inform companies and managers of their responsibilities under HSWA 2015. At the same time, mental health literacy should be incorporated as an aspect of the Site Safe training which is required for all employees on site.

Because construction is such a high-risk industry, employees are expected to be aware of and follow many H&S actions and procedures. More frequent review of company policies and expectations around mental health and other H&S would be beneficial for all employees. Currently the two companies studied provide employees with a company induction upon first starting with the company, a site-specific induction when starting at each new project, and a site-specific re-induction when workers start back after the Christmas/summer break. Inclusion of elements of the company induction, including mental health aspects, into the annual re-induction could ensure that employees are up-to-date on what is required of them and aware of available support. This would reiterate the companies' commitment to employees' wellbeing, and contribute to more robust compliance with the legislative requirements.

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