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Research Article

The development of a depressive disorder management model amongst Thai labours in the Eastern Economic Corridor (ECC)

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Abstract

Depression is a barrier to the human workforce. However, the lack of major policies and guidelines for depression disorder in Thailand hinders healthcare workers from addressing this issue. Therefore, this research examines ways to develop depressive disorders in laborers. This study used a qualitative approach to examine the context of depression management in labor. The results of this study presented factors related to depression management from individual to organizational contexts. This finding suggests that stakeholders should take the first step of depression prevention outside healthcare services.

Introduction

Depression refers to a psychological illness that is presented by the emotion of sadness, loss of interest, or pressure of normal activities [1]. Depression disorders lead to other health issues and serious healthcare conditions because they interfere with sleep patterns, appetite, and tiredness [2]. Between 2005 and 2015, the WHO found that more than 300 million people faced depression disorders [2]. Evidence of depressive disorders leads to disability, particularly in developing countries [3]. Zenebe, et al. [4] argued that the prevalence of depression in developing countries (40.78%) is higher than in developed countries (17.05%). In developing countries, more than 75% of patients with depression disorders did not receive corrective treatment [5]. From this evidence, people who had depression disorder in development were suffering and poorly functioning to work and perform activities, especially those in the working period [6]. People of working age present high rates of suicide, low quality of work, antisocial, absent from work in frequency, separated from other co-workers, lead to disability, and impact economic improvement [1,6,7]. Therefore, the depression in working age needs to concern in particular developing countries. In Thailand, a developing country, the incidence of depression has increased from 4.6% in 2015 to 10.8% in 2019 [8]. As a result, the Ministry of Public Health in Thailand developed the first national development plan for mental health and focused on depression disorders in the working age between 2018 and 2037 [9]. However, the national development plan for mental health was not fashionable in Thai health policy [10]. This was because of the limitation of economic status and other disease pandemics [11,12]. The limitation was referred to in a few studies on depression in workplaces in Thailand [10,11,13,14]. In the deep information of the national development plan for mental health, the implementation has focused only on hospital-based care [9]. To improve the policy of mental health in the workplace, the Department of Mental Health in Thailand

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needs to understand all structures of depression care including the workplaces, the healthcare structures such as healthcare services, mental health centers of health region, and the provincial health office, and the structure of labor and welfare consist of the office of Labor protection and Welfare, and the Social Security Office.

In the economic areas of Thailand, the Eastern Economic Corridor (ECC) is one of the major economic areas consisting of three provinces, Chonburi, Rayong, and Chachoengsao, which had a working age population increase triple from 2018 to 2020 [8]. Most of the worker population in this area migrated from rural areas of Thailand due to economic issues [15,16]. The change from rural to industrial areas increases stress for them from being unaccustomed to experience, lifestyle, health, safety, and financial security, which leads to mental health issues such as depression [17].

To improve the depression care system, this study aimed to understand the pattern of care for depression in the current context and the barriers to care for working-aged people in ECC. The researchers also expected to find ways to improve the quality of care for depression disorders in both policy and practice for working-aged people in economic terms.

Method

Participants

The research employed a purposive sampling strategy to identify and recruit participants who work within Thai healthcare settings, companies in EEC, and government officers in labor and welfare organizations. This method of sampling participants is based on the objective of the research, which is to improve the care for depression disorder in working-age individuals in Thailand. The participant groups included employees, managers in the companies, human resources officers, safety officers, company nurses, health officers in provincial health offices, social security officers, and labor protection officers. It was anticipated that the overall sample would comprise 28 participants.

Inclusion criteria

Employee

- Thai people who work in companies or factories in EEC and are aged between 18 and 60 years.
- Fully conversant in the Thai language
- Willing to participate and able to provide informed consent.

Managers in companies, human resources officers, safety officers, company nurses, health officers in provincial health offices, social security officers, and labor protection officers

- Willing to participate and able to provide informed consent.
- Hold a position relevant to responsibility with people who have depression disorders.
- Have at least two years' experience.

Recruitment

The researcher contacted each organization, including the companies (employees, managers in the companies, human resources officers, safety officers, and company nurses), provincial health offices (health officers in provincial health offices), social security offices (social security officers), and the office of labor protection (labor protection officers), by phone to explain the information on the research objective and collect data, which is required in relation to ethical approval, recruitment support, and research support.

Data generation

Data was generated through audio-recorded, individual, in-depth interviews. After collecting the data, the research used transcriptions, note-taking, and audio recordings from each interview. The interviews were professionally and carefully transcribed in Thai language. On completion of the translation process, the researchers discussed any translation or meaning issues with the research team until an agreement was reached.

Data analysis

After transcribing the data, the researchers carefully read all of the transcriptions word by word to gain a sense of the whole data. The coding and group categories were developed in the next process. Thematic analysis was used to analyse the data in order to understand the phenomena in the research context.

Ethical consideration

Ethical approval was obtained from Burapha University Human Research Ethics Committee code HS 030/2563. Prior to their involvement in the study, the participants were informed about the processes and time involved. All participants were assured that the information would be collected anonymously and treated with strict confidentiality. The participants had the right to withdraw at any time.

Confidentiality and anonymity

All the data collected in this study will remain confidential. In this research, the researcher stored the documents to ensure the trustworthiness of the data. During the research period, the data collection sheet, transcript, and other documents were kept in a locked cabinet with access only to a key located in the researcher's office, Faculty of Nursing, Burapha University. Audio-recorded data were stored in a locked cabinet with access only to a key located in the researcher's office, Faculty of Nursing, Burapha University. After the research was completed, the processed data were stored in a locked cabinet, as per Burapha University's management of the research data policy.

Folders and files are named in an uncomplicated and logical manner in drive H, which can only be accessed by the researcher. A backup copy of all the data is also stored on the external hard drive and under locked conditions. Moreover, all

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participants' answers and responses remained confidential and part of the dataset; therefore, identities were protected at all times. All responses were stored securely and designated with a unique code, and no names were included in the interviews or transcripts.

Results

Participant demographic

The demographics of all participants were summarized in Table 1 as shown:

The definition of depression disorder

From the data, the participants interpreted the depression disorders as feelings of sadness, unhappiness, lazy to work, hopelessness, stress, negative attitude, and loneliness.

I1P1 "*Depression is the psychological symptoms refers to stress and cannot do anything.*"

I2P1: "*Depression is like staying alone, not important for others. If breading but nonexistence for every people, they don't want to live.*"

I4P2 "*They are not come to work, separated themselves from other co-workers, unconcentrated to work, and slow progression.*"

Context and condition of depression disorder

After data utilization, the context and condition of depression disorders of labor in ECC were identified under three themes: less accessibility, hidden care, and individual management.

Table 1: Participant demographic.

Data	(N = 28)	Percentage
1. Type of stakeholders		
- Employees	5	17.85
- Manager	8	28.56
- Human resources officers	4	14.28
- Safety officers	3	10.71
- Company nurses	3	10.71
- Social security officers	2	7.14
- Labor protection officers	2	7.14
- Health officers in provincial health offices	1	3.57
2. Gender		
Male	8	28.57
Female	20	71.43
3. Age (year)		
Younger than 20	1	3.57
20 years - 39 years	6	21.43
40 years - 59 years	21	75.00
(Mean = 42.52, SD = 11.34)		
4. Education		
- Undergraduate	4	14.29
- Bachelor's degree	20	71.42
- Master's degree	4	14.29

Less of accessibility: Less accessibility refers to the fact that laborers in ECC had less access to proactive depression disorder care, such as the lack of a survey or evaluation in labor, lack of a depression database for working age in ECC, and lack of a platform for coordination and contract with other stakeholders who influenced depression management care. Moreover, the management of depression disorders in the workplace also increases costs.

"*We did not have information of depression care in workplace. We had only the law of flout and infringements.*" I11P3:

"*The employees never talk about stress or mental health issues with administrators that the reason that we don't have project or channel for depression disorder in our factory.*" I12P5.

"*We do not have the mental assessment form or checklist to evaluate depression. Because the nurse works in nursing room and the employees came to see our in this room. We cannot come to evaluate all of employees to prevention depression disorders.*" I16P7.

"*For my concern, cost and expense will be increase, if we have service for depression management care such as paid for psychiatrist or nurse specialists.*" I6P8.

"*Almost all companies mention on physical health issues than mental health issues. This was because physical health issues directly impacted work. The I6P8.ession disorder as the vacuity. No people talk about it.*" I7P6.

Hidden of care: Due to the lack of a unit of people directly responsible for depression disorders in the workplace, depression disorders are considered hidden care. The participants mentioned the following:

"*The employees pay attention to work in the frontline. They did not have time to talk about depression or mental health issues.*" I2P8.

And

"*We lack time to consult mental health with other people, but it hidden in working period. If the employees find someone who open mind and understand them, the employees also talk with them. However, the consult is in general.*" I5P6.

Individual management: Individual self-management as the participants noted:

"*We know the depression disorder must selfcare because the company is not do anything. The depression disorder as the individual issues* I2P5.

"*If I had stress or sadness, I would be talk with co-workers. The co-workers can support and understand me. It makes my stress can release.*" I11P12.

The factors are influenced by the depression disorder in working age at ECC

The data presented three factors related to depression

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disorder in working age, including the attitude toward depression disorders, knowledge and management skills, the context of companies, and policy.

Attitude: Employees who had experienced stress or depression disorder were uncomfortable living. They fear that others are pretending or bullying them, which makes them mortified. Almost all the workers who had depression disorder were not told their condition to others, as the participants noted:

"*If I talk with other people, I feel embarrassed because I don't know what they think about it*" I2P5.

However, managers or human resource officers can observe them from the often-absent work and lack of concentration to work.

"*The workers who had depression sometimes they do not trust me. They did not talk about it. This issue refers to the human resource officers lack of depression disorder data from our employees.*" I4P6

Knowledge and management skills: Workers lack the basic knowledge and skills to evaluate and manage depression.

"*I knew someone who had depression disorder, but he did not accept. In this time, I saw him stress and lack of ability to work. I came to approach him and advised him to see the nurse and consult with human resource officers. However, he refuses to do this until his family brings him to the hospital*". I1P7.

"*The employees may not know that they faced with depression disorder, but when I talk with them, I also known they had mental issues. They also complain about their family, their responsibility, and they clinical symptoms*." I3P5.

The company contexts: Company context refers to a company's size, environment, and welfare. The company's size includes the number of employees. The environment refers to the company's management, working atmosphere, and co-workers' relationships that impact depression disorder management in the workplace. Moreover, welfare also increased opportunities for employees to reduce depression disorders, such as scholarships for their children, shuttle buses for pick-up their employees, and others.

"*Our company had around 100 employees. The administrators provide accommodation, shuttle bus for pick-up, the money to support health besides public health insurance, meals, and sport days that twice times per year. I think it can release stress and made healthy for employees*." I1P5.

"*The first benefit as the company provides facilities for us such as dining areas and areas for relaxation. Following with company management. The last things as the incomes and compensation*' I3P4.

"*Welfare is importance for employees. My company as the Japanese company is not pay the high salary for employees. However, the welfare is good. My company has bonuses, scholarships for employees' kids, gifts for marriage, birthday gifts and vacation, and others*". I5P5.

The policy: The policy also includes the company's policy and the policy from the relational organization, as the data presented:

"*We support standard tools, safety measurements, and health check-ups. But we are not mentioned in the psychological context*' I6P5.

"*The company supports the physical issues than mental issues. For example, if the employees had illness or unwell, they (administrator in company) sent these employees to healthcare services*." I12P6.

Pattern for managing depression disorder in the work-place

From the suggestion from participants, the way to develop patterns of managing depression disorder as integrated healthcare and workplace for depression disorder by including the process of assessment, reconciling the depression disorder, setting the system for companies to support employees and evaluation.

"*My previous workplace had doctor to visit employees every week. For my opinion, it's good to assessment patients before had serious issues in mental health*" I1P3.

"*Safety officers may discuss with the head of divisions to assess their employees. Because they also know who is at risk with depression disorder. The other way that the company has training or courses for increase the knowledge of depression disorder*" I3P5.

"*I think the safety officers should educate employees about the depression disorder and find the way to prevention this issue*." I4P5.

"*The law should be mentioned to the psychologist for factory or company. At present, the law mentions nurses in a factory within 24 hours. However, the employees do not dare to talk about mental issues*" I5P7.

"*I had discussed with nurse to develop the program for depression disorder care with managers and human resource division. It may reduce the burden of depression on employees.*" I28P5.

Discussion

Depression management in the workplace depends on the context and condition of the workplace, as Steadman and Taskila [18] argued the employer should support employees in managing and preventing depression. This is because the workplace is an important organization for reducing or increasing the cause of depression disorder [19]. Rasool, et al. [20] mentioned that a toxic workplace increases the incidence of depression at a higher level. The toxic workplace refers to the toxic culture, and toxic leaders in work organizations [21]. A toxic workplace reduces productivity, raises organization costs, and high the turnover rate of employees [22]. Therefore, stakeholders in the workplace or company are the important key people to reduce depression disorder for employees.

From the study, the factors that are influenced by depression disorder in working age had been categorized into four domains including an attitude toward depression disorders, knowledge

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and management skills, the context of companies, and policy. The attitude of depression disorder is the stigma for employees to leave their jobs and increase the severity of illness. This is because attitude has been shown to have a negative effect on the toxic psychological cycle [23]. As Conway, et al. [24] noted social face and speech are negative and harmful to the brittle mind. From the knowledge, management skills, and policy, the World Health Organization [25] suggested that the guidelines and policy of safety for industry need to involve both physical and psychological terms. In the domain of patterns for the management of depression disorder, Dinis, et al. [23] argued that depression disorder in the workplace needs integration with stakeholders who relate with employees to develop care during every stage of protection, prevention, treatment, and promotion. While the context of the company is important to increase the prevalence of depression. The workplace environment such as less pressure, role clarity, and autonomy may benefit an employee in preventing depression [26]. Heinz, et al. [27] studied the intervention to reduce depression in organizations presenting that the positive organization context is associated with the low score of depression in employees. The last dimension, the policy of depression in the healthcare system needs to be integrated with both public and private sectors to prevent and reduce the severity of depression in Thailand. Coretti, et al. [28] suggested that a deeper understanding of depression and the economic burden from the depression is important for developing countries at the starting point to be concerned with cost-effectiveness and the policy strategies in the future.

The limitation of the study is that the Thai cultural background does not reveal depression disorder. Therefore, the number of participants who were willing to interview in this study was limited.

In terms of future research and implications, the intervention of depression management from individual organizations is very important to reduce the severity of depression in the workplace. Another recommendation for future research will be to study depression in the workplace with migrant employees who work at the ECC (Eastern Economic Corridor).

Conclusion

In conclusion, this research presents evidence to support depression management in the workplace in developing countries. The lack of a core policy for depression disorder care in the workplace refers to all organizations in the workplace, healthcare organizations, government welfare officers, and public health insurance organizations cooperating in the channels to reduce the serious issues of depression disorder in working age. Our findings also suggest a way to create a strong policy to protect labor from depression. Future research is needed regarding the implementation of depression programs for labor in both experimental and longitudinal studies.

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Declaration

Paper's Title: The development of depressive disorder management model among Thai labors in the Eastern Economic Corridor (ECC)

1. The authors hereby certify thatWe participated in the conception of the paper and made public my responsibility for its content.
2. All information concerning any source of funding received for the development of this research has been properly disclosed and made available to the editors during the submission.
3. There were no connections or agreements between authors and funding sources that constitute any conflict of interest, potential or apparent, that may affect the results of the research.
4. That the manuscript is original and that the research is not in part nor in whole currently submitted to another periodical, either in print or in an electronic format, nor is any other material of my authorship with substantially similar content so submitted.
5. If requested, I will provide and cooperate fully in obtaining and providing data on which this text is based, for the editors' examination.
6. I have read and agreed with the terms of the Open Access and Data sharing.

Share upon reasonable request policy

This research is performed under the qualitative approach. All data collected in this research was kept confidential. In this research, the researcher stored the documents for the trustworthiness of the data in Thailand. During the research period, the data collection sheet, transcript, and other documents were kept in a locked cabinet with access only with a key, located in the researcher's office, Faculty of Nursing, Burapha University. Audio-recorded data was stored in a locked cabinet with access only with a key, located in the researcher's office, Faculty of Nursing, Burapha University. Furthermore, after the research is completed, the processed data is stored in a locked cabinet as per Burapha University's management of research data policy.

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Disclosure of interest

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