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REVIEW ARTICLE

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Workplace-related determinants of mental health in food and bar workers in Western, high-income countries: A systematic review

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Abstract

Background: This review synthesizes evidence from etiologic and intervention studies of workplace-related determinants of mental health in workers in food and bar workers in the hospitality industry in Western high-income countries.

Methods: Peer-reviewed literature published between January 2000 and August 2023 was gathered from five bibliographic databases. Any study design was eligible. Study quality was assessed using the Joanna Briggs Institute tools for appraisal.

Results: A narrative analysis was conducted for 26 included studies (total n = 15,069 participants) across Australia (3), Ireland (1), Norway (1), Spain (2), the United States (17) and the United Kingdom (2).

Individual and task-related factors such as high emotional job demands and low job control were associated with high burnout and depression. Uncivil and hostile interpersonal interactions with customers, management, and colleagues were found to contribute to poor mental health outcomes, including depression, anxiety, and burnout.

Conclusion: Findings from included studies highlight the impact of workplace culture, including management practices and workplace social support, on mental health. Organization-level interventions may therefore be most effective for addressing individual, interpersonal, and organizational determinants of mental health in food and bar occupations, particularly when implemented as part of broader organizational efforts to support health and wellbeing. Industry-wide policy changes may also be necessary to address structural concerns, including job and financial insecurity, job strain and access to benefits, such as secure sick leave and minimum contract hours.

KEYWORDS

anxiety, bartenders, burnout, depression, hospitality industry, industry conditions, mental health, psychological distress, waiters, workplace-related determinants

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1 | INTRODUCTION

The World Health Organization's World Mental Health Surveys estimate that up to 47% of people will experience a mental disorder in their lifetime.[1] In 2021, an estimated 23% of all US adults experienced a mental disorder in the previous 12 months.[2] In Australia, 25% of women and 18% of men aged 16–85 reported a 12-month mental disorder in 2020–2021, with women reporting higher rates of anxiety disorders than men and men reporting higher rates of substance use disorders.[3] During 2020–2021, just under half of both US adults aged 18 and over and Australians aged 16 and over with a 12-month mental disorder sought mental health support from a health professional.[2,3]

Despite increased investments in mental health services in recent years, prevalence of mental disorders has not decreased and, in some population groups, notably young people, may have increased.[4] While increasing the availability and uptake of mental health services is important, this is unlikely to reduce the prevalence of mental disorders unless attention is also given to upstream determinants; one of which is the work environment.[5] While unemployment is associated with mental health problems, poor quality work also poses risks to mental health[6] and there is evidence that these risks may vary between industries and occupations. Approaches tailored to specific work environments may therefore be necessary to address workplace-related determinants of mental health.[7–12]

Accommodation, hospitality and food services (hereafter referred to as "hospitality") is one of the largest industrial sectors worldwide. In the United Kingdom (UK), for example, hospitality accounts for 10% of the employed workforce, making it the third-largest private-sector employer,[13] and in Australia, it accounts for 6.7% of the Australian workforce overall.[14–16] Within the hospitality industry, the food and beverage service sector (hereafter referred to as "food and bar") is one of the largest subsectors. In 2021, this subsector accounted for 4.1% of all employed residents across England and Wales and has been 1 of the 10 highest employing industry divisions in the United Kingdom since 2011.[17] In 2023, 90%–96% of Australian and United States (US) hospitality workers were employed in food and bar occupations, most commonly as waiters, chefs, kitchenhands, bartenders and baristas.[15,18] In the United States, 1 in 3 food and bar workers are immigrants and 1 in 2 are women, although diversity levels vary between occupations.[15] In Australia, for example, 75% of waiters in 2023 were women, compared with 27% of chefs. In the United States in 2021, 68% of waiters and 53% of chefs and head cooks in the United States identified as white.

Many young people have their first paid work in food and bar service.[19,20] Among working 16–24 years olds in the United States in 2023, for example, approximately 20% were employed in food and bar occupations, with hospitality and leisure industries more broadly being the largest employers of people in this age group.[19] In 2021, the largest concentration of workers were between 16 and 24 years old and this age group accounted for approximately 40% of the US food and bar workforce.[15,21]

Entering the workforce is a defining and critical stage of development,[22] and typically coincides with early adulthood, which is a critical time for the onset and severity of mental disorders. A recent meta-analysis of 192 studies worldwide (n = 708,561) reported that the proportions of individuals with onset of any mental disorder before the ages of 14, 18, and 25 years were 35%, 48%, and 63%, respectively.[23] Moreover, many hospitality workers are immigrants, a group also at higher risk of common mental disorders. In a systematic review across 12 countries, 62% of studies found that immigrants were more likely to present or develop anxiety, depression or somatic disorders than those native to their destination country.[24] Ensuring healthy working conditions may play a key role in reducing the risk of mental health problems in vulnerable people. Given the proportion of vulnerable groups employed in the industry, the association between hospitality work and mental health warrants scrutiny.

1.1 | Mental health in the hospitality industry

Studies of hospitality employees suggest that depression and anxiety are prevalent[25,26] and burnout is a burgeoning concern.[27–29] Risky alcohol and substance use are also well-documented in the industry; high to extremely high use is common, culturally ingrained and poses a serious concern for workers' mental health.[30–34]

Literature on the hospitality industry encompasses occupations in accommodation, food, beverage and occasionally tourism services, within which specific occupations have been associated with mental health problems. A UK-based household survey, for example, reported that bar staff, chefs and waiters were among the occupations experiencing the highest prevalence of common mental disorders[35] Between 2011 and 2020, bar staff were identified among the occupations with the highest risk of death by suicide for women across the United Kingdom.[36,37] Similarly, a 2021 US mortality report identified bartenders, chefs and head cooks amongst the five occupations with the highest rates of death by suicide for women[38] and a 2022 Australian study using population-level data from between 2006 and 2017 found that chefs of any gender were more likely to die by suicide, compared with those working in non-hospitality occupations.[39]

1.2 | Occupational exposures and mental health

The working conditions that typify food and bar work such as long and anti-social hours, job strain, precarious employment and casualisation[40] are suspected contributors to poor mental health.[41–45] Observational studies in other industries have also demonstrated clear associations between shift work, psychological impairment and development of depressive symptoms.[46] Within this occupational group, some populations may be at particular risk of exposure to poor working conditions. Migrant or temporary visa populations, for example, are at high risk for job insecurity and up to

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75% of migrant workers experiencing job insecurity and other dimensions of precarious employment report poor mental health.[47,48]

Workplace hostility through negative colleague interactions such as aggression and bullying are concerning problems within food and bar occupations, notably between managing chefs, junior staff and apprentices in kitchens.[49] Literature abounds on the associations between workplace hostility and poor mental health in other industries, and an umbrella review[50] of robust, international meta-analyzes found that workplace hostility was associated with depression, anxiety and stress-related psychological complaints over time. Further, poor baseline mental health was also an indicator for future experiences of workplace bullying.[51]

Workplace-related risks to mental health may be buffered by perceived organizational support and social connections in the workplace, although evidence is not always consistent.[52,53] Perceived organizational support is rooted in social-exchange theory[54] and is an employee's perception that their organization values their work and well-being, and they can speak openly with their manager or organization and receive appropriate assistance during periods of job stress.[55] In other industries, this has been linked to lower prevalence and intensity of depressive and burnout symptoms.[55,56] food and bar venues are inherently social, with extended hours and tasks requiring close collaboration between colleagues. Social connections at work have been shown to protect against work stress, burnout and depressive symptoms in otherwise stressful occupations including paramedics, anaesthesiologists and nurses.[57–59]

Noting that bar staff, chefs, cooks and waiters are all food and beverage service positions, the established relationships with common mental disorders and the risk of death by suicide and proportion of at-risk demographic groups working in these jobs, the aim of this study was to systematically review the evidence on workplace-related determinants of psychological distress and common mental disorders in this specific occupational group within the hospitality industry.

2 | METHODS

This review was informed by the PRISMA reporting guidelines[60] and the protocol was registered with Prospero in April 2022 (CRD42022311587).

2.1 | Search strategy and terms

A systematic search of available literature was conducted, with search terms and criteria developed using a SPIDER framework [Sample, Phenomenon of Interest, Design, Evaluation, Research Type], according to advice on qualitative and mixed-method reviews (see Appendix SI).[61–66]

The first author of this article (TG) conducted searches of five databases between May 2021 and August 2021, updating these searches in August 2023 to gather any additional articles published since the initial searches. Searches were conducted in five databases: Gale OneFile: Hospitality and Tourism, ProQuest Central, PsycINFO, MEDLINE (OVID), and Web of Science. To be eligible for this review, studies were restricted to those available in English and published after 1/1/2000 (see Appendix SII for an example search).

2.2 | Eligibility criteria

Studies were eligible for inclusion if the study population included employees aged 16 years or older who were currently, or had previously, worked in the hospitality industry in a Western, high-income, OECD country (as defined by the World Bank).

The hospitality industry includes hotels, casinos and cruise ships, with occupations and duties ranging broadly across card dealers, cleaners, receptionists, restaurant, café and entertainment workers. This review focuses on food and bar-service occupations, including both "front-of-house" (e.g., waiters, bartenders, baristas, hosts, and venue managers) and "back-of-house" (chefs, dishwashers, and kitchenhands). Studies with samples drawn from specific and unique tourism or service industries such as airline, cruise-ship or hospital workers were excluded. Mixed hospitality samples were included if they included 50% or more food and bar workers.

There were no restrictions on eligible study designs, and qualitative and quantitative studies were included. Studies that assessed the impact of any working or employment conditions, for example, physical strain, job demands, job stress, emotional labor, bullying, harassment of all sorts, job insecurity, job control, supervisory or co-worker social support were considered for inclusion. Eligible studies were those incorporated a validated measure of symptoms of common mental disorders (depression, anxiety disorders or burnout), for example, the Depression, Anxiety and Stress Scale (DASS-21), the Kessler Psychological Distress Scale (K10) or the Maslach Burnout Inventory (MBI-GS). Quasi-experimental studies and trials were eligible if they manipulated a workplace-related factor and incorporated a validated measure of common mental disorders.

2.3 | Selection and data collection process

Studies identified through the searches were imported into Covidence, an online program designed to assist in screening and assessing articles for systematic review.[67] The first author (TG) screened abstracts and titles in Covidence for key terms and identified studies for full-text review. Studies identified for full-text review were assessed by the primary researcher (TG), with 25% reviewed by an additional researcher (SO) for quality control. Discrepancies were resolved through discussion between the two reviewers.

2.4 | Risk of bias assessment and certainty of evidence

Methodological quality of included studies was assessed according to the Joanna Briggs Institute (JBI) Qualitative Critical

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Appraisal Checklist, the JBI Checklist for Analytical Cross-Sectional Studies and the JBI Appraisal Checklist for Randomized Controlled trials for risk of bias assessment.[68] All studies were assessed by the first author (TG) and were verified by a second reviewer (BH and JND) with any disagreements resolved through discussion.

2.5 | Synthesis methods

Data from included quantitative and qualitative studies were analyzed separately before being integrated in both the descriptive tables and the narrative synthesis in this article.[62] Informed by guidelines for synthesis without meta-analysis,[69] studies were grouped for synthesis by contextual factors, first by the broad category of social or macro-economic workplace-related element/s examined, then by study design and where possible, by specific occupations or demographic factors such as age and gender. This review prioritized findings from studies assessed as having a low risk of bias, non-cross-sectional study designs and the closeness of the research question to the aims of this review.

3 | RESULTS

Systematic searches across the five databases returned a total of 6088 articles. After the removal of duplicates, titles and abstracts of 4292 unique records were screened for eligibility. A total of 241 articles were retrieved for full text screening of eligibility. Of these, 19 cross-sectional, 3 qualitative, 3 longitudinal and 1 intervention study were included in a narrative synthesis—26 in total. The PRISMA flow chart of records gathered, included and excluded is outlined in Figure 1.

3.1 | Quality assessments

Quality assessments revealed that studies were a mix of mostly medium and high-quality, with three low-quality studies included (see Appendix SIII-V). Observational studies were mostly a mix of high and medium quality; however, two studies were rated as low quality. Among the qualitative studies, two were rated as high quality and one low quality. The included intervention study was rated as medium quality. Poorer scores were most often driven by the confounding domain, with 10 studies having unclear or missing descriptions of

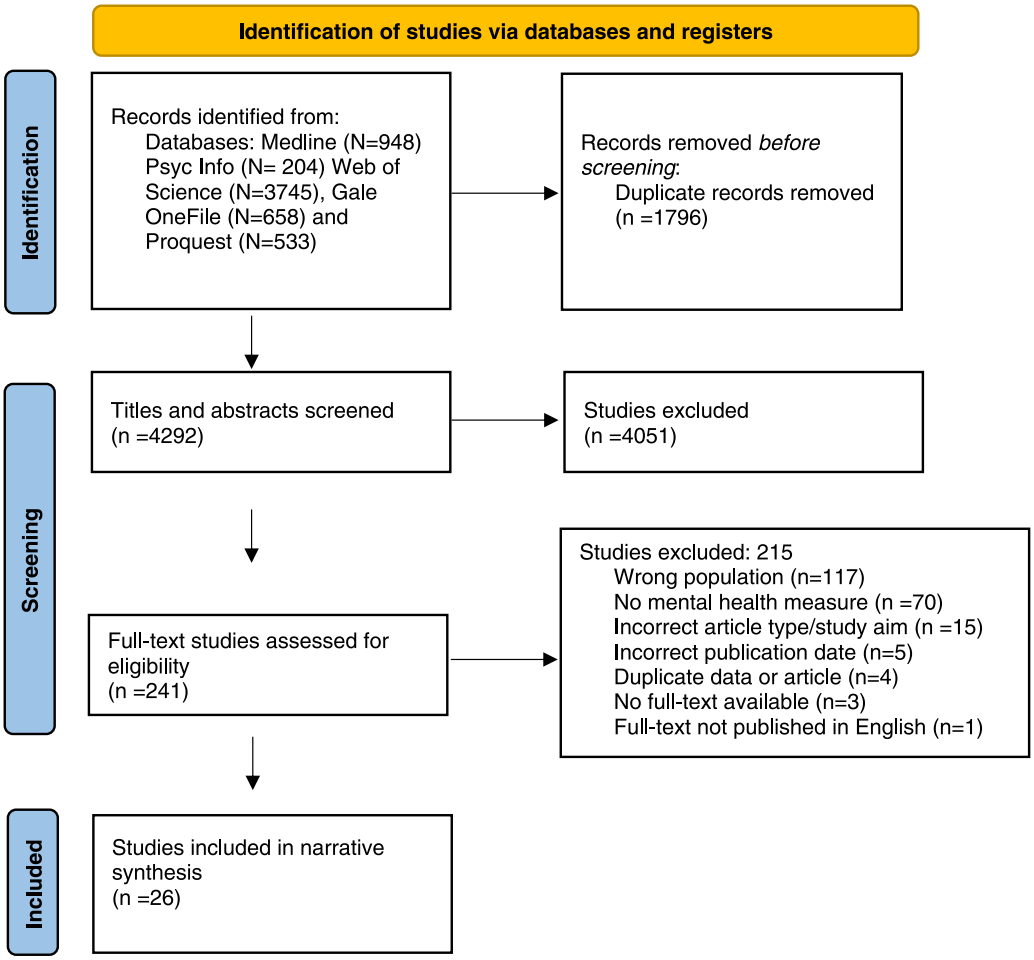

FIGURE 1 PRISMA flow chart.

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adjustment for confounding. Moderate scores were mostly driven by unclear criteria. Studies were considered high-quality if they met all of the criteria on the JBI Appraisal Checklist relevant to study type.

3.2 | Samples

A summary of demographic and organizational details can be found below in Table 1. Studies totaling 15,193 participants were conducted in Australia (3), Ireland (1), Norway (1), Spain (2), the United States (US) (18) and the United Kingdom (UK) (2). 79% of samples were mostly women (19). The most frequent age groups sampled were 25 years and under and 35 and older, and cumulatively the majority of studies (51%) predominantly sampled participants younger than 30.

3.3 | Measures

Mental health measures included Maslach's Burnout Inventory (MBI), Center for Epidemiological Studies Depression Scale (CES-D), Kessler Measures of Psychological Distress (K10), Patient Health Questionnaire-9 (PHQ-9) and the General Anxiety Disorder-7 (GAD-7).

3.4 | Main findings

Across 26 included articles, 14 food and bar workplace-related factors were reported to have associations with common mental disorders and psychological distress. The majority of studies (14) focussed on elements of burnout, while seven focused on depression and four on anxiety, post-traumatic stress disorder and psychological distress. Applying a socioecological framework, the workplace-related factors spanned individual, interpersonal, organizational and structural-level influences. Individual influences included personal, emotional and task-related factors. Interpersonal influences included customer interactions and social relationships between colleagues. Organizational influences included management practices, workplace policies and venue styles. Structural influences included industry, national and global-level factors such as economic conditions, government policies and legislation.

The workplace factors and related mental health problems are presented in Table 2, grouped by broad socioecological level. Further descriptions of the methods and main findings of each of the 26 included studies are provided in Appendices SVI-SVII.

3.5 | Individual and task-level factors

3.5.1 | Self-esteem and satisfaction

In two included studies, chefs and waiters with either low job satisfaction or organization-based self-esteem (the extent to which

TABLE 1 Summary of demographic and organizational details by frequency and proportion of included studies.

	# of studies	% of included studies
Country		
Oceania		
Australia	3	12%
Europe		
Ireland	1	4%
Norway	1	4%
Spain	2	8%
United Kingdom	2	8%
North America		
United States	17	65%
Age[a]		
Mean age or predominant age-group[b]		
25 and under	8	32%
29 and under	6	24%
34 and under	4	16%
35+	7	28%
Gender[a]		
Majority of sample		
Women	18	72%
Men	7	28%
Job position[c]		
Area		
BOH	2	8%
FOH	13	52%
FOH and BOH	10	40%
Occupations[d]		
Bar service		
Bar staff	4	15%
Baristas	1	4%
Kitchen		
Chefs	4	15%
Cooks	2	8%
Apprentices	1	4%
Kitchenhands	1	4%
FOH service		
Waitstaff	10	3%
Hierarchical position		

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TABLE 1 (Continued)

	# of studies	% of included studies
Managers	8	31%
Supervisors	2	8%

[a]One study did not report age and gender.

[b]>50% or most-concentrated age group, from available data.

[c]One study did not specify job positions.

[d]Figures are not mutually exclusive, most studies included multiple occupations.

workers "perceive themselves as important, meaningful, effectual, and worthwhile within their employing organization"[98]) were significantly more likely to report burnout symptoms than more-satisfied colleagues.[74,75] Controlling for work-unit size and contract type, multi-level modeling indicated that 46% of waiters were experiencing low-moderate job satisfaction and moderate-high emotional exhaustion and cynicism.[74]

3.5.2 | Emotional and cognitive job demands

Job demands can be distinguished by the type of effort required, including cognitive or emotional effort.[70] Regression analysis in a United States cross-sectional study suggested that only emotional job demands had a significant relationship with burnout across a broad sample of baristas, waiters, managers, chefs and bartenders.[70] This relationship may be mitigated by job control, as workers were less likely to report burnout if they felt a high sense of control over the timing and methods of meeting emotional job demands.

Three studies identified job demands requiring significant emotional labor in food and bar occupations: racial code-switching, service-improvisation and "service-scripts."[71–73] Notably, these job demands were most often associated with customer-facing occupations and all samples consisted of either entirely or predominantly of front-of-house workers. Racial code-switching, defined as the expectation that workers shift to "proper English" at work, rather than the cultural or racial colloquial speech they would otherwise use, was linked with depression in restaurant staff, potentially because of increases in identity threat and shame.[73] Workers who used high service improvisation strategies, defined as the process of modifying established routines and finding creative solutions for complaints and unexpected situations at work to placate and exceed customers' expectations, were likely to report high emotional exhaustion.[71] "Service scripts" or "display rules" describe the social and organizational expectations of how women should present while working in customer-facing positions, namely, appearing consistently welcoming, hospitable, encouraging and subordinate. In one UK qualitative study of current and former bar staff, women indicated that adhering to display rules often required surface-acting techniques ("a false emotional display that is faithful to organizational norms"[99]) and bred feelings of depersonalization and exhaustion. Experienced workers noted that surface-acting became more routine and less emotionally taxing the longer they worked in the industry.

3.6 | Interpersonal factors

3.6.1 | Customer incivility

Three studies focussed on traditional, face-to-face interactions with customers, including unwanted sexual attention. Given this focus, these studies sampled front-of-house staff exclusively, finding that bartenders, casual and fine-dining restaurant employees experiencing customer incivility were likely to also report burnout symptoms.[72,76,100] When receiving unwanted verbal or physical sexual contact from customers, for example, female bar staff often felt expected to maintain service scripts. Presenting an outwardly warm and welcoming demeanour created notable emotional dissonance (a disconnect between outwardly expressed emotions expressed during surface acting and deeper inner emotions).[72] Junior, less-experienced workers were more likely than senior staff to be deeply emotionally affected by unwanted attention from customers and to ruminate on these experiences outside of working hours, however, workers of all ages and industry tenures expressed feelings of burnout, unease, vulnerability and exhaustion which continued outside of the work environment.

With the increasing popularity of online reviews, traditionally back-of-house roles such as chefs are now also exposed to some customer-related social stressors. One US study conceptualized burnout as a chronic form of job strain,[77] finding that receiving negative online reviews predicted increases in anger and cynicism, and decreases in personal efficacy in owners, managers, chefs and front-of-house staff across a broad range of restaurant types, from fast food to fine-dining. Negative online reviews did not, however, have a significant effect on emotional exhaustion.

Customer incivility may also have a spill-over effect into colleague relationships; waiters experiencing customer incivility and burnout were likely to also report being uncivil to co-workers, including raising their voices and ignoring or excluding colleagues while at work. This effect was avoided when employees had high emotional intelligence.[100]

3.6.2 | Workplace incivility

Bullying behaviors between workers both back and front-of-house were regular, sometimes daily, occurrences of workplace hostility and those who identified as a victim of bullying were more likely to be aggressive or withdrawn at work, report high cynicism (burnout) and feelings of depression.[78,79] Workers in Norway and the United States described consistent criticism or reminders of past mistakes, having necessary workplace information withheld, being ignored, shouted at, the target of rumour-spreading or spontaneous anger, and, most

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TABLE 2 Summary of workplace-related and mental health problems research using socioecological framework.

Socioecological level	Workplace factor	Mental health problem	Measures[a]	Studies	Reference
Individual	Emotional job demands	Burnout	MBI, semi-structured interviews	Schmitt (2019), Green (2022), Oh, Jang (2023)	[70–72]
		Depression	10 3-point scales (from Baer et al., 2000)	Garlington, J, Shum et al. (2023)	[73]
	Job control	Burnout	MBI	Schmitt (2019)	[70]
	Job satisfaction	Burnout	MBI	Kang, Twigg, Hertzman (2010), Beniteztiz, Peccei, Medina (2019)	[74, 75]
Interpersonal	Customer incivility	Burnout	MBI, 16 items adapted from MBI, 6 items (Demerouti (2001)	Han (2016), Kim, Qu (2019), Weber, Bradley, Sparks (2017)	[76, 77]
	Unwanted sexual attention	Burnout	Semi-structured interviews	Green (2022)	[72]
	Workplace hostility	Burnout	MBI, semi-structured interviews	Mathisen, Einarsen, Mykletun (2008), Smith (2021)	[78, 79]
	Communication skills	Psychological distress	K10	Pidd, Roche, Fischer (2015)	[80]
	Workplace social support	Burnout	MBI, Human Services Inventory	Schmitt (2019), Bufquin (2020), Wallace, Coughlan (2022)	[70, 81, 82]
		Depression	4 7-point scales	Haslam, O'Brien, Jetten, Vormedal, Penna (2005)	[83]
Organization	Management styles	Burnout	Oldenburg Burnout Inventory	Teo, Nguyen, Shafaei, Bentley (2021)	[84]
		Depression	Five-item short scale (Bohannon et al; 2003)	Ruiz- Palamino (2022)	[85]
	Perceived organizational support	Burnout	MBI, 16 items adapted from MBI	Han (2016), Walters, Raybould (2007), Kang, Twigg, Hertzman (2010), Oh, Jang (2023), Schmitt (2019)	[70, 71, 75, 76, 86]
	Sexually-objectifying working environments	Anxiety	GAD-7	Szymanski, Mikorski (2017)	[87]
		Burnout	MBI	Szymanski, Mikorski (2016	[88]
		Depression	CES-D	Szymanski, Feltman (2015)	[89]
Structural	Salary structure (tipped/untipped)	Depression	Modified Epi Studies Depression Scale- 10	Andrea et al. (2018)	[90]
	Job loss/insecurity (Pandemic-related)	Anxiety	Semi-structured interviews	Rosemberg et al. (2021)	[91]
		Depression	PHQ-9, IES	Chen and Chen (2021)	[92]
		PTSD	Primary Care-PTSD Screen	Rosemberg et al. (2021)	[91]
		Psychological distress	MHI, 10 5-point scales of negative affect or distress	Grandey, Sayre, French (2021), Bufquin et al. (2021)	[93, 94]
	Job strain (Pandemic-related)	Anxiety	Semi-structured interviews	Rosemberg et al. (2021)	[91]
		PTSD	Primary Care-PTSD Screen	Rosemberg et al. (2021)	[91]
		Psychological distress	MHI	Bufquin et al. (2021)	[93]

Note: Framework adapted from Battams et al.,[95] McLeroy et al.,[96] and Scarneo et al.,[97]

[a]Maslach's Burnout Inventory, Center for Epidemiological Studies Depression Scale, Impact of Events Scale, Mental Health Inventory, Patient Health Questionnaire, General Anxiety Disorder Scale, Eating Attitudes Test-26.

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commonly, being ordered to do work below their level of competence. Misuse of power within organizational hierarchies contributed to patterns of bullying behaviors, which were often preceded by periods of high workplace stress. Managers and supervisors were commonly the perpetrators of workplace hostility, most often towards apprentices and junior staff. Notably, apprentices did not always identify negative behavior towards them as bullying. Victims also indicated that bullying behaviors could include both the initial comment or action, and ensuing laughter from colleagues at their expense, which resulted in feelings of shame and increased feelings of depression.[100]

3.6.3 | Social identity and support

Four studies highlighted the mental health benefits of positive social interactions with colleagues and supervisors.[70,81–83] Front-of-house restaurant and bar staff in Ireland, United Kingdom and United States who identified with their work group, perceived social support or held positive social opinions of their supervisors and colleagues were less likely to report burnout than workers who were more isolated from their colleagues. Workers employed on temporary contracts (no minimum hours), however, may not benefit as much from social support, with one of these studies noting no significant relationship between burnout and supportive interactions with managers for these workers.[82]

Distinguishing further between emotional and instrumental workplace social support, Schmitt (2019) found that, in combination with high job control and low emotional demands, emotional social support from colleagues and supervisors likely protected against burnout in front-of-house restaurant staff. Instrumental social support, however, such as practical assistance for tasks did not have a significant effect on burnout in this study.

In Australia, a randomized controlled trial[80] assessed the impact of training in personal coping, communication strategies and identifying and reducing workplace-related risks of psychological distress in apprentice chefs. The intervention involved two training sessions over 2 weeks (3 h total), the first focussed on personal coping strategies and communication skills with colleagues, managers, friends and family, the latter focussed on identifying and reducing risks of using alcohol and substance-related harm as a coping strategy. Following intervention, participants demonstrated improved ability to discuss workplace issues with managers, coping with verbal abuse and reduced psychological distress compared to a control group.

3.7 | Organizational factors

3.7.1 | Sexually-objectifying work environments

Compared to those in family-style venues, women working front-of-house in sexually objectifying environments (e.g., "Hooters") were more at risk of burnout, anxiety and depression in three US cross-sectional studies.[87–89] These studies suggested that sexually objectifying environments contributed to the risk of mental health disorders by increasing body shame and by facilitating and promoting unwanted sexual advances and sexual objectification both from customers and from management. It was not uncommon for male managers to review, comment on and request more alluring attire from their female workers. Organizational support and management practices

Seven included studies outlined the potential mental health benefits of organizational support (the perception that aid from the venue is available if needed to complete tasks effectively), supervisory support (the perception that managers or supervisors care about and make efforts to support workers well-being), "servant leadership" and "high commitment" management practices.

In Australia[84,86] and the United States,[70,75,76] workers front and back-of-house who perceived higher levels of organizational or supervisory support from managers reported lower burnout than workers who perceived low or no organizational support, particularly when combined with high job control and limited emotional job demands. Perceived organizational and supervisory support may also mediate some customer-related job stressors; workers experiencing customer incivility or high service-improvisation demands who perceived high support from managers and supervisors experienced lower burnout symptoms than modeling predicted.[71,76] Further, working under supervisors who focused on employee's needs, personal and professional development, in addition to fostering a supportive environment and providing social support was associated with high personal social capital, and low prevalence of depression in both active and furloughed workers during pandemic lockdown measures.[85] Known as "servant leadership," this management style is characterized by supervisors who consider themselves part of the team and are perceived as motivated to support workers and serve team goals.

"High commitment" management practices supporting job control/autonomy and limiting job demands were also associated with low burnout in food and bar workers.[84]

Hallmarked by workers perceptions of justice, job stability, training and fair pay, these practices aim to trust workers to complete their work relatively independently and encourage them to connect emotionally with the culture and goals of their workplace). High-commitment practices were not, however, common amongst the workplaces sampled and burnout scores rose notably with the age of participants.

3.8 | Structural factors

3.8.1 | Salary structure

A longitudinal US study[90] following participants from 14 years old into adulthood identified a relationship between gender, working in tipped service roles (e.g., waitressing) and depression. A regression analysis of a nationally-representative sample controlled for race,

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household income, education, migrant status, parent's education, childhood sleep, childhood general health and highest childhood depression scale score, reported that women working in tipped service roles were significantly more likely to report depressive symptoms than women working in untipped service roles or non-service roles. Further, when the analysis was narrowed to women with no previous history of depression, those working in tipped service roles were more likely to receive a depression diagnosis than those working untipped service roles. No significant relationships between depression, stress and occupation type were found for men.

3.8.2 | Job strain, job insecurity, and pandemic-specific factors

Public health management strategies during the early stages of COVID-19 exacerbated existing systemic problems in food and bar employment conditions, including job strain, limited or no annual or sick leave entitlements or benefits, vulnerability to illness as frontline workers, job insecurity due to mass casualisation and consequently, financial insecurity due to inconsistent pay, underemployment and limited or no rights to severance pay.[85,91–94] Some pandemic-specific effects were also recognized in those who continued working, including fear of catching or transmitting the virus.

Employees who continued working throughout 2020–2021 reported significantly higher psychological distress than furloughed employees in one cross-sectional study[92] and in a qualitative study[91] working participants reported feelings of anhedonia, detachment, and anxiety. The same study also screened for PTSD and found that symptoms were higher for participants living in US states with medium and high COVID-19 case numbers. In both studies, the mental health problems associated with working early in the pandemic were linked to job strain due to increased job demands from customers and workplaces.

Workers who experienced work loss (became unemployed, had reduced hours or were furloughed) were likely to experience psychological distress, symptoms of anxiety, depression, or PTSD, which were attributed to financial insecurity, and limited or uncertainty of employment rights and benefits.[91–93] In contrast, a longitudinal study across the United States and United Kingdom reported that work loss did not have a direct effect on psychological health, however, did have an indirect effect through job threat.[94]

4 | DISCUSSION

Based on our synthesis of 26 eligible studies, 14 individual-, task-, interpersonal-, organizational- and policy-related factors were associated with common mental health problems and psychological distress in this occupational group. Many of these workplace-related factors have been described in other industries, particularly client-facing occupations such as nursing and customer service. Findings of this review align with the broader workplace wellbeing literature in those occupations and provides useful, occupation-specific detail of the context of food and bar workplaces.

Our findings align with previous systematic reviews of studies in the hospitality industry more broadly, or in countries outside of the scope of this review, including those focused on specific mental health problems such as burnout.[28,29] In our review, emotional job demands and customer incivility were the most commonly studied factors, indicating that at present, these factors have the most evidence supporting their potential effect on mental health in this occupational group. Findings of this review highlighted the importance of organizational climate, with factors such colleague and managerial relationships protecting against workplace-related stressors on all sociodemographic levels. Further, there was some evidence suggesting that exposure and reactions to working conditions may differ with some demographic and organizational factors, including job position (front or back-of-house), age, gender, race or ethnicity and job tenure and organizational hierarchy and future research could expand on these findings with further nuance.[72,73,76]

Despite the proportion of at-risk demographic groups in the workforce, along with the known prevalence and severity of common mental health disorders and psychological distress in this occupational group, only one intervention study addressing workplace-related determinants of mental health was identified in this review. Further research is therefore needed to examine the potential methods and benefits of programs addressing workplace-related factors as upstream determinants of mental health in food and bar workers. Individual factors.

Mirroring the findings from broader reviews in tourism,[27,101] job demands that required significant emotional effort were associated with common mental disorders and findings suggested that the amount of emotional effort exerted for these tasks may be higher for some demographic groups than others.[72,73] Workers from culturally and linguistically diverse communities, including migrant workers, for example, may feel pressure to employ racial code-switching during customer-facing tasks, and thus may exert more emotional effort than some of their colleagues while performing similar tasks.[73] Similarly, in this and other studies,[102,103] women in customer-facing roles appear to experience higher emotional job demands and surface-acting than men in similar roles, given the greater social and organizational expectations for how cheerful and subservient they should appear while working, and that they more likely than men to receive backlash for not consistently performing these emotions. Future research should examine in more detail the relationship between emotional job demands and demographic factors such as age, gender and cultural background. Informed by those studies, inclusive and culturally-sensitive interventions could be developed to support mental health in food and bar workers.

4.1 | Interpersonal factors

The relationship between negative client/customer interactions and the risk of common mental disorders for providers is a

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well-established pattern in service occupations, including nursing and customer service[104–106] and was evident in the findings of four included studies.[72,76,77,100] Previous research in service occupations has also demonstrated that women are more likely than their male colleagues to experience customer incivility, which was similarly reflected in this review.[107,108] Further, the age or experience of workers may affect the impact of these interactions on mental health; younger or more junior women were more likely than older or more-experienced colleagues to be deeply emotionally affected by negative customer interactions.[72] Due to the diversity of studies, limited samples and limited detailed demographic data available, it was not possible to conduct a detailed analysis or comparison of mental health outcomes between age or cultural groups in this review. Future research could expand on this with a larger quantitative diverse sample of food and bar workers, examining whether associations are present for other population groups and intersectional positions.

Experiencing negative interpersonal interactions from customers may increase some job demands due to the amount of effort required to bridge the emotional dissonance between how a worker may feel and how they are expected to appear at work.[72,76,102] Given that poor customer interactions were common, and may exacerbate other workplace-related stressors and contribute to poor mental health outcomes, customer-related stressors may be a critical area for future research and health-promotion activities aiming to protect and promote mental health in food and bar occupations.

Consistent with previous meta-analyzes of poor social climate and workplace hostility across industries,[43,45] poor relationships with colleagues (particularly between junior and senior staff) were also closely associated with burnout and depressive symptoms in food and bar workers.[74,78,100] Although some health initiatives such as mindfulness, coping skills, nutrition, exercise programs have been tested,[80,109] it appears that few comprehensive mental health intervention programs have been evaluated and reported in the peer-reviewed literature in food and bar or wider hospitality settings.[110] However, given the significant proportion of at-risk groups in the workforce, the prevalence and severity of mental disorders amongst food and bar workers, inclusive, culturally-sensitive and occupation-specific mental health interventions may be needed.[23,25,30,35–39] As previous research has largely focussed on individual factors and managing reactions to workplace stressors, future research could take a preventative approach, addressing upstream interpersonal determinants of mental health in food and bar workers.

4.2 | Organizational factors

In a 2022 report on cultural issues in Australian hospitality, managers were the second-most common perpetrators of unwanted sexual advances towards staff, accounting for 42% of reported incidents.[111] This is reflected in the findings from three food and bar studies of sexually-objectifying working environments, however, findings should be considered with some caution as these studies exclusively sampled female and non-binary identifying workers.[87–89] Organizational culture is an issue across sectors but may be acute in food and bar workplaces because of the team-based nature of the work and established hierarchical employment structures. Meta-analyzes including samples from occupations with similar organization structures offer some support in this area.[112–114] Studies of health professionals, government employees and the military, for example, have found that unwanted sexual advances from colleagues are associated with depression, suicidality, PTSD and severe psychiatric symptoms.[112,113] Workplace sexual harassment has also been linked with suicide attempts and death by suicide in a population-based sample.[114]

Reflecting research across hospitality and other industries,[43,115,116] positive experiences with management and colleagues emerged as protective and supportive factors for mental health in food and bar workplaces in six included studies.[71,75,76,84–86] Perceived organizational support, for example, along with management practices that promoted job control, low job demands and fair pay were associated with high personal capital, low burnout and low depression. Further, in some studies supportive colleague relationships appeared to buffer against the expected effects of other workplace-related stressors, such as customer incivility and unwanted sexual advances.[76,88]

Taken together, the individual, interpersonal and organizational-level findings gathered in this review highlight the importance of organizational climate, suggesting that factors such as colleague relationships and managerial support may be promising areas for future research and preventative interventions to support food and bar workers. Psychosocial health and wellbeing research across other industries suggest that organizational-level, workplace-based interventions are effective for supporting mental health, particularly when implemented as part of broader organizational efforts to support health and wellbeing.[117–122] Noting that there is a complementarity between occupational health and safety regulations and human right legislations and informed by previous programs implemented in Canada and recently in Australia,[123–125] organization-level interventions could be developed for food and bar workplaces, focussing on the positive duty of workplaces to take proactive, preventative measures to protect staff wellbeing. Overarching, integrated interventions could be implemented at an organizational level, incorporating complementary strategies across three domains: preventing harms, promoting positive aspects of work and responding to problems.[126]

To inform integrated interventions, future research could begin with scoping surveys across a diverse sample of workplaces, asking workers, managers and owners to identify hazards and assess risk levels in workplaces using psychosocial climate benchmarking measures such as the PSC-4 and PSC41 which have been validated in Sweden and Australia.[127,128] These scoping studies could also aim to develop and trial measures to assess the organizational and demographic contexts contributing to incivility from customers and between colleagues and to identify opportunities to promote workplace social support, as the effectiveness of workplace-based interventions is hugely dependant on organizational context, including colleague participation and managerial support.[129,130]

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Future interventions could trial implementing interpersonal skills training in parallel with organizational-level policies designed to prevent and respond to harms. Informed by evident utility of training sessions in communication strategies for junior staff,[80] interventions could include similar interpersonal skills training for all staff, including managers and senior workers, aiming to reduce workplace hostility and promote supportive colleague relationships across all ages and workplace hierarchies. Organizational-level policies could include directing customer complaints only to managers and zero-tolerance responses[131] for any anti-social behavior including sexual advances from both colleagues and customers, including provisions for reporting incidents to appropriate regulatory bodies. Anti-incivility interventions, including zero tolerance policies have been trialed in nursing occupations with mixed results. When implemented to address workplace-incivility between colleagues, interventions were effective, particularly when broad institutional efforts to improve workplace culture were made. Zero-tolerance policies for incivility from patients were less effective, as nurses felt obliged to continue their duty of care responsibilities,[132] however, such policies may have more success in food and bar workplaces, given that staff may feel more comfortable to refuse service than service providers in healthcare settings.

4.3 | Structural factors

Findings in this review build on reports of the psychological repercussions of the pandemic on labor and industry.[133] Crucially, most of the food and bar work-related determinants of poor mental health identified during this time, such as job strain and job insecurity, existed before the pandemic. As both employment and trade levels have been slow to recover,[134,135] these factors may still be contributing to mental health problems in food and bar workers and so are unlikely to improve in the future without targeted policy intervention.

Structural-level determinants of mental health such as job and financial insecurity could be addressed by implementing industry-wide policies that aim to target related industrial factors such as widespread casualisation.[40] In developing these policies, OECD countries could be informed by some policies implemented locally, such as the sick leave guarantees in New Zealand[136] and that are currently under trial in Australia for select industries with high proportions of temporary workers, including hospitality.[137] Similarly, policy interventions could an option to guarantee minimum hours or convert to a permanent contract after working on a temporary contract for more than 6 months.[138] Last, industry-level pay scales and minimum wages could be reviewed and adjusted, particularly in regions where tipping is expected to offset low wages.[90]

4.4 | Strengths and weaknesses

The strength of this paper is that it offers a comprehensive review of the literature on mental health in a specific at-risk occupational group, across a range of common mental disorders and psychological problems, synthesizing studies conducted pre-and post-COVID-19 and provides useful, occupation-specific detail to inform future research and support initiatives, including interventions implemented from a workplace to structural level.

This review trialed and used a comprehensive set of search terms, however, given the variety of terms used to describe food and bar service workers, it is possible that relevant articles were missed. Quantitative synthesis was not possible due to the diverse studies gathered and due to the largely cross-sectional studies included, the direction of association between the workplace-related factors and mental health outcomes is inherently unclear, leaving potential for reverse causation and limiting causal inference. This also points to a key limitation in the available evidence, and a need for better quality data. The conclusions drawn from this review are also limited by the heterogeneity in included risk factors and mental health measures. While mental health outcomes were validated, there is also the potential for misclassification error. Similar to previous systematic reviews of burnout and work environments,[12] many included studies focussed solely on emotional exhaustion, omitting cynicism or personal achievement/efficacy measures.

This review was also limited to OECD countries, and thus results cannot be generalized to low-income contexts. Most studies included were also conducted in the United States, further limiting generalizability across countries and sectors. Lastly, the conclusions drawn in this review are limited by the research methods, quality and variety of sample populations of included studies, particularly given the number of medium and low-quality studies which did not identify or appropriately control for some confounding factors in their analyzes. The notable absence of intervention studies also points to the need for further rigorous research in this area.

5 | CONCLUSION

The findings of this review highlight the impact of workplace culture, particularly of management practices and colleague relationships, on mental health in food and bar workers. Organization-level interventions may therefore be most effective for addressing individual, interpersonal, and organizational determinants of mental health in these occupations, particularly if implemented in parallel with industry-wide changes to wage, contract and benefit policies to address structural concerns.

AUTHOR CONTRIBUTIONS

Tessa Grimmond participated in every stage of this review from conception to final revision. Tania King, Anthony D. L Montagne, and Nicola Reavley supervised this review, participating in the conceptualization, interpretation of data and revisions of the work for publication. Sanne Oostermeijer, Benjamin Harrap, and Jackson Newberry-Dupe participated in the analysis of data and provided revisions of later drafts. All authors contributed to and approved the final revision of this work for publication.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DISCLOSURE BY AJIM EDITOR OF RECORD

Jian Li declares that he has no conflict of interest in the review and publication decision regarding this article.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

ETHICS STATEMENT

This work was performed at the Melbourne School of Population Health, University of Melbourne, Melbourne, Victoria, Australia. As this was a systematic review of published work, ethics review was not required.

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