MHPP (Mental Health and Productivity Programme)

Final Report Executive Summary

Purpose

This summary is intended to provide a high-level overview of the final MHPP report. It provides an outline of what was undertaken during the programme and the results that were achieved. It also outlines several recommendations for policy leads and employers to consider.

What was MHPP?

The Mental Health and Productivity Pilot (MHPP) was a collaboration, led by Coventry University with key partners including the University of Warwick, West Midlands Combined Authority, and the mental health charity Mind. It was commissioned in July 2019 with the broad aims of:

- Contributing to a social movement to promote mental health and wellbeing in the workplace.
- Reducing the impact of poor mental health in the workplace and barriers to employability and productivity
- Delivering evidence-based, locally relevant, tested, and sustainable solutions
- Seek to examine the link between mental health and productivity within a workplace setting.

The strength of the partnership rested not only with its reach and the strength of the individual partner organisations but also its capability as a collegial, combined delivery team, leveraging existing expertise, capacity, and diversity – in terms of both the types of organisations as well as the skills and resources they bring. In particular, the partnership provided a combination of academic rigour, practitioner experience and employer engagement through partners' links and engagement with intermediary bodies. a combination of academic rigour, practitioner experience and employer engagement through partners' links and through engagement with intermediary bodies.

MHPP worked across the Midlands Engine – a region with a diversity of organisations as well as a blend of urban and rural economies and with one of the lowest Gross Value Added (GVA) levels in the UK[1] thereby making it a suitable testbed for this agenda, particularly from a place-based perspective. At its heart, MHPP created a social movement for workplace mental wellbeing moving the agenda building on the work of the Thriving at Work Report (2017)[2].

What did MHPP deliver?

During the first year, MHPP undertook several reviews with stakeholders including Public Health England, NHS England Local Authorities, and professional bodies and held several focus groups with organisations and employees to identify key areas for workplace mental health interventions. It identified core organisations' products such as the 'Mental Health at Work Commitment' curated by Mind and West Midlands Combined Authority's Thrive at Work Accreditation scheme, which were chosen to amplify across the region. Both programmes were offered to organisations with additional engagement support to aid implementation and delivery within the organisation.

[1] GVA is defined as the value of the goods and services produced minus the value of the intermediate inputs that were used to produce those goods and services. It can be calculated for firms, industries, local and national economies. Subtracting the value of intermediate inputs is important – it avoids double counting, and it gives us the value of output that can be shared out between workers and owners Understanding GVA - What Works Growth

[2] Thriving at Work: the Stevenson/Farmer review on mental health and employers (publishing.service.gov.uk)

Learning from these focus groups and reviews led to several new interventions being developed that were undertaken as academic trials. The following interventions were identified:

- Enabling managers to increase their confidence when dealing with staff with poor mental health (Managing Minds)
- Supporting managers to connect with individuals who were off sick to return to work (PROWORK)
- Supporting the employee to remain in the workplace and to help people with mental health problems improve their psychological flexibility, engagement, and interpersonal relationships at work. MENTOR (Mental hEalth conditions to remain eNgaged and producTive at wORk)
- Support to employees experiencing mood regulation challenges (REST), poor sleep hygiene (SLEEP), and disordered eating (BITE), support to employees experiencing mood regulation challenges (REST), poor sleep hygiene (SLEEP), and disordered eating (BITE).

In addition, an anti-stigma campaign 'Bridge the Gap, Start a Chat' was created, building on the evidence from the Time to Change programme (which ended in March 2020), focusing on encouraging open conversations at work about mental health and providing employees, managers and organisations with tools to do so. This campaign also acted as a lead-generation tool to drive organisations to MHPP's core interventions.

During the review of MHPP, it was recognised that employer-level data was being recorded with organisations working on either Mental Health at Work Commitment or Thrive at Work. Developing an understanding of the change that these and other mental wellbeing interventions were making was deemed necessary to support the ambition of identifying the link between mental health in a workplace setting and productivity. This led to the evaluation of the MHPP Enhanced Offer via an academic natural experiment. As such, a programme of work was undertaken with 42 organisations which took them on a journey which supported employer-level data capture; employee baseline survey; feedback report to the organisation; creation of a bespoke Action Plan; consultancy support to aid implementation and then follow up employer and employee data collection.

What did MHPP find?

MHPP operated for four years with an aim to unlock - what is often described as - the mental health and productivity puzzle. The programme sought to generate learning and improvements through workplace interventions which supported employers and employees to remain mentally healthy in the workplace setting. The programme identified that this is an extremely complex subject matter and some of the key findings are highlighted below.

MHPP provided significant support to **over 1,130 organisations directly reaching over 800,000 employees in the Midlands region**. However, there were lower than anticipated levels of interest for free support from employers due to **competing issues of Covid, Brexit and more recently, the cost-of-living crisis impacting the ability to take up the support**.

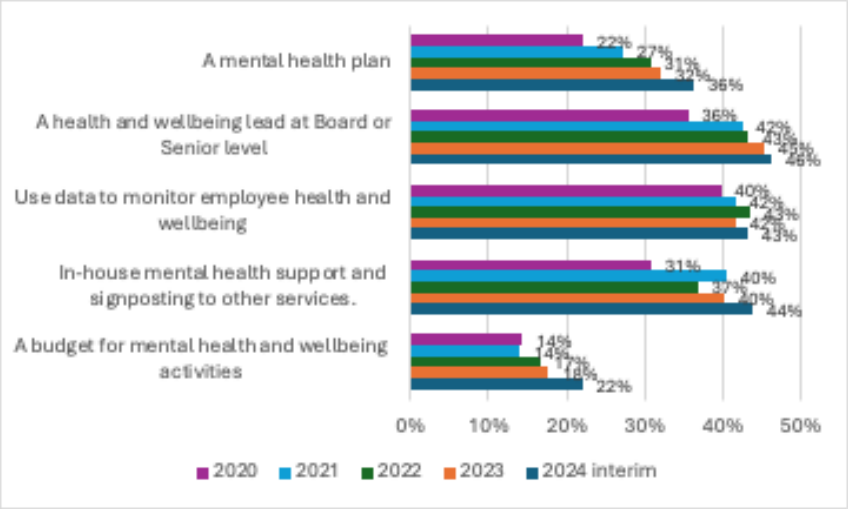
Throughout the programme, different partners have produced innumerable versions of customer journeys and engagement routes; **there is no 'one size fits all' or 'silver bullet' in this space** and the approaches had varying levels of success. This reinforces the view that it remains challenging to design such a programme for a national-level audience. It also identified that MHPP contributed to a social movement approach promoting mental health and wellbeing with a parity of esteem with physical health and safety in the workplace.

Despite interest from employers wishing to take part in the programme in the early days (Sept 2020), **significant work was required to convert that initial interest and engagement into sign-up** and participation. This was a significant challenge for all the research and delivery pilots, despite the offers being free at the point of delivery. This was more notable in multi-national organisations and public service bodies where governance frameworks can often be seen as disablers to quick decision-making as well as challenges to mobilise within short delivery periods. As identified in the natural experiment, it was easier to progress programmes such as this within **small and medium enterprises where the decision-making levels are less hierarchical**. This was a particular challenge for the Thrive at Work and the Mental Health at Work Commitment delivery teams who despite having trusted brands met their objective but were challenged with recruitment levels and speed.

MHPP identified that whilst **organisations see the importance of workplace wellbeing**, **organisational budget specifically for wellbeing remains low**. It is evident that many organisations were pleased to take part in MHPP, the qualitative interviews suggested this was in part due to the offer being free.

Economic analysis of the Enhanced Offer element of MHPP identified a return of investment (ROI) of £1.29. Most recent data from ERC's presentation (2024) (Figure 1) shows the stubborn level of **growth by only 8% over five years of organisations willing to invest in a budget for health and wellbeing activities**.

Figure 1: Proportion of firms with strategic initiatives (ERC (Enterprise Research Centre) data on all firms, 2024)



However, the data shows that despite the lack of investment by organisations there has been positive movement in the Midlands organisations with a **14% increase in firms having a mental health plan and a 10% increase in senior leadership engagement and in-house support or signposting** to other services to be offered.

Researchers identified when working with organisations, that although the MHPP offer of intervention was free at the point of delivery, **it did require the organisation to commit resources to support adoption and implementation**. This was likely to be from members of the HR (Human Resources) team, wellbeing leads or senior lead, an individual or team of staff to implement the programme and assist other staff to deliver the intervention. In addition, it was necessary to understand how much time staff will need to have away from the 'day job' to train or to develop the necessary knowledge and skills to support this agenda. The role of the Engagement Officer (as part of the Enhanced Offer) was instrumental in supporting the journey for many organisations. Although a time-limited resource,

the evidence suggests that this **hand-holding support helped organisations to move the agenda further and faster**.

MHPP identified through the qualitative and quantitative research undertaken through the Enhanced Offer that the **workplace is an environment where positive changes and impact can be made and seen in a short space of time**. However, the evidence is not strong enough to suggest that organisational-level workplace interventions lead to improved individual level mental health outcomes in the short term; the emerging evidence does suggest that cultural shifts are being made, which in turn, over time may lead to improved health outcomes. This was supported by the MHAW Theory of Change generated by Mind and Warwick University[3].

Single points of failure were a common theme throughout the project. Working with organisations proved to be challenging when the identified lead was a single individual. There were many occasions during the projects when individuals were absent on leave or through sickness which left a void for the delivery teams. Good organisations create multiple leads and wellbeing champions to minimise this and share the tasks across the organisation.

It was also identified that **line managers are critical** to any work within either the workplace wellbeing agenda or cultural change. Evidence from the employee survey in the natural experiment suggested that managers had limited training, knowledge, or confidence to deal with mental health problems or wider sickness absence. The concept of 'accidental managers' is relevant here where managers are recruited primarily on their technical skills to deliver in the organisational context rather than the behaviour competencies that make them good managers. They acknowledged that training undertaken to date included awareness of mental health conditions but not how to deal with them in the workplace arena. Work undertaken by MENTOR, PROWORK and Managing Minds has created new learning which can support line managers to deal more effectively with this at an earlier stage, reducing the potential for extended sickness absence and staff turnover due to ill health.

MHPP found how **difficult this landscape is for organisations to navigate, in terms of use of health and wellbeing data**. Most organisations and business processes use evidence make informed decisions; it is clear from our study that some **organisations are not using data-driven insight to drive the decisions** of what wellbeing intervention works best for their organisation. On average, 42% of firms use data to monitor the health and wellbeing of staff. MHPP found that **most organisations and in particular SMEs did not know how to use their data effectively to improve the health and wellbeing of their workforce or identify interventions** that would support the health improvement. This was most notable with sickness absence where - although data was captured - it was perceived to be of poor integrity and did not necessarily capture the reason for the sickness absence in enough detail to be useful.

Evidence from the MHAW Commitment qualitative interviews, undertaken as part of the evaluation by the University of Warwick[4], identified that one of the major barriers included the **reluctance to reduce mental health experiences to statistics.** There is a perception in SMEs that reporting on data may be more relevant for larger organisations and they were unable to prioritise collection or analysis. There was one organisation that stated that to prevent data collection from becoming a mere tick-box exercise, the process should be measured externally in order to implement a level of accountability.

[3] Mind and University of Warwick Mental Health at Work Programme Report. Reports referenced in Final Report - OneDrive (sharepoint.com)
[4] *Ibid*.

Half of the employer representatives identified MHAW as a positive motivator, by raising awareness and encouraging organisations to commit to data collection efforts.

The same report consistently highlighted that data that is collected plays a crucial role in shaping mental health strategies and informing action planning at both employee and senior leadership levels. Linking to the quantitative survey findings however, over a third of organisations (36%) did not feel they have the expertise to analyse mental health data and form relevant recommendations and 27% did not use data to inform their plans.

The survey showed that **larger organisations were more likely to understand measurement techniques and collect data**, but **medium and micro-organisations were most likely to have the expertise to analyse and use this data to inform their practices**. Finally, while most organisations interviewed had some form of data collection, they acknowledged its evolving nature and expressed plans for further enhancements.

Employer representatives also emphasised the need for clearer guidelines, best practices, increased support from MHAW, and a genuine commitment to sustainable data collection practices.

Throughout MHPP, the **availability of data is a significant challenge**. Organisations are not required to maintain data on workplace wellbeing and as such there was a plethora of approaches being taken or in some cases none. The researchers identified several organisations that did not collect any wellbeing data at all, including no sickness absence data. One organisation kept manual written records which meant every request for data required a manual search. On the other extreme, there were organisations larger in size that had very sophisticated data collection approaches. It became apparent that data integrity is a challenge for most organisations. Some organisations recognised that the data was only as good as that which was inputted. Organisations required managers to input the data but from the qualitative interviews, focus groups and site visits compliance was limited.

Organisations also conduct many surveys i.e., Investors in People Award, annual staff survey, employee engagement surveys, and Great Place to Work survey to name but a few. Our analysis shows a level of **survey fatigue from employees**. Our evidence found that staff did not always hear back from the results of the surveys, so they felt undervalued and did not see the value in taking time to complete them. As part of the MHPP Enhanced Offer, employers were given the tools to ensure that results were shared and requested that they were posted on intranets or other means within the organisations. In addition, the Engagement Officers undertook feedback sessions on behalf of the organisation as independent researchers.

The programme recognised the **value of data as a tool to support the identification of relevant interventions**. It is necessary for data to be triangulated from a variety of sources to create a holistic picture of the organisational wellbeing and that of its employees. More work is needed to identify the full suite of indicators necessary for organisations. The survey questions leading to the creation of the MHPP Status Report would provide a strong basis to work from. These validated questions included but not exclusively, SWEMWEBS, EuroQol EQ5D-5L, the 6 Management Standards, awareness, and confidence of dealing with mental health and sickness absence. Working with employers MHPP found that the EuroQol EQ5D-5L, which is primarily a clinical measure for quality of life, was suboptimal as a measure for the workplace setting.

It is important that employee surveys are undertaken purposefully. We found that a smaller set of validated questions should be used to reduce the impact on employee time and reduce the feeling of survey fatigue. Results and proposed actions should then be fed back to those who participated as early as possible to complete the feedback loop.

The programme also identified that the wellbeing landscape is difficult to navigate for employers with a **need for multiple levels of decision-making**. Do organisations and businesses need to commission an employee assistance programme, or occupational health advisor or develop a structure in the organisation which tackles the main contributors of workplace health? This is an important question considering the recent occupational health consultation and the potential national standard.

MHPP worked with partners to develop an evidence-based approach to support organisations and businesses. Working with key partners, strategic approaches, action plans and interventions were produced and implemented. It is evident from the wellbeing marketplace that there are many wellbeing frameworks in existence across the UK. However, the **evidence suggested that the extra support from the Enhanced Offer has been helpful for employers to create a structured approach within the organisation** rather than an ad-hoc approach which happens organically, responding to emerging challenges as they arise i.e., prolonged sickness absence, high levels of workplace stress or harassment or bullying caused by the behaviour change of employees moving through the mental health continuum. The analysis from the employer surveys suggested that they would implement perceived quick fixes such as Pilates or yoga sessions, providing Mental Health First Aiders or offering free fruit in the office on a Friday. These interventions, which on their own, may work or at best cause no harm, but on their own do not provide a strategic long-term solution that is rooted in promotion or prevention interventions or tackle the causes of workplace stress through tackling the challenges identified within the 6 HSE management standards.

Employee level changes

MHPP worked primarily with employers to shape their improvement to workplace mental wellbeing. It was recognised that the impact on the employee should not be underestimated. The workplace has been identified as a pertinent and sustainable setting for providing mental wellbeing support at scale, whilst overcoming the many barriers to accessing timely treatment through traditional healthcare pathways. Given the consequences of delayed treatment on exacerbation of symptoms and costs to both the employer and the wider economy, there is a demand for preventative approaches to strengthen individuals' protective characteristics (e.g., resilience, and emotion regulation skills) against poor mental health outcomes.

From the individual-level pilots, we saw improvements in wellbeing outcomes in the individual-level interventions in a short space of time (SLEEP and MENTOR), but this was not demonstrated for the Enhanced Offer.

MENTOR demonstrated through the quantitative analysis that psychological distress significantly decreased, whilst productivity, work engagement, psychological flexibility, and interpersonal relationships all significantly increased from baseline to post-intervention. It also identified that stress levels decreased over the course of the intervention, work engagement, interpersonal relationships and psychological flexibility increased. Additionally, as positive mood increased, so did psychological flexibility. Several of these relationships were found to be moderated by baseline levels of psychological distress. Finally, the quality of managers' relationships with their employees significantly improved over the course of the intervention.

The **SLEEP** study aimed to establish the efficacy of a hybrid dCBT-I+ER programme (SLEEP) offered to employees in workplaces on insomnia, depression, anxiety and other wellbeing outcomes, and productivity. On average, at baseline, all randomised participants were presented with moderately severe clinical insomnia, mild to moderate symptoms of depression, and mild to moderate anxiety. Results showed that this hybrid intervention significantly reduced all three symptom outcomes for

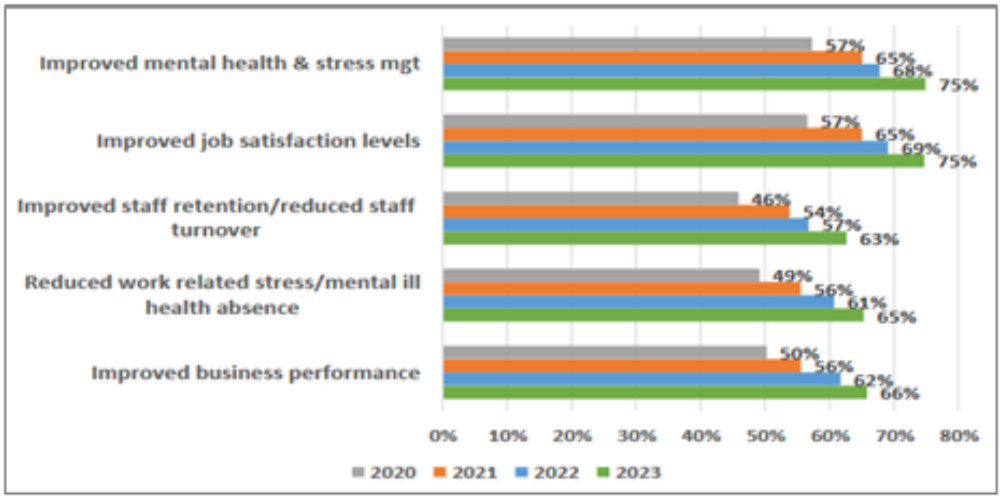
those in the dCBT-I+ER arm with large effect sizes. Whilst the intervention did not show a significant effect on productivity-related outcomes, these may need to be explored in future larger trials where the study is powered enough to detect smaller effect sizes.

The pilots also identified the important contributions to the staffing and training model. This demonstrated the viability of delivering such interventions via the workplace by non-clinically trained staff, highlighting a more accessible avenue for support to working individuals outside of routine clinical care. This is particularly important in the current context where the health workforce is under such pressure and new models of workforce can be developed outside of the clinical environment.

MHPP has started what could be described as a social movement for the workplace wellbeing agenda in the Midlands. In Figure 2, data from the longitudinal survey conducted with firms in the Midlands by ERC (2023) shows a positive position. From the organisations surveyed, there has been an 18% improvement in mental health and stress management and job satisfaction levels: a 17% improvement in staff retention or reduced staff turnover and a 16% reduction in work-related stress and mental health absence **as well as improved business performance (productivity).**

This cannot be causally attributed to the work of MHPP – however, with the level of work undertaken across the region over the last four years and feedback from organisations who have taken part in our programme – we can say that MHPP has been a contributing factor.

Figure 2: Reported impacts of mental health activities in all firms (ERC data, 2020-23)



MHPP Final Recommendations

1. **Provide SME-focused mental wellbeing support**:

   SMEs identified that they benefited from the additional capacity (Enhanced Offer) to support the implementation of workplace wellbeing programmes in their organisation.

   a. Consider the development of an **incentive to support SMEs** like a levy or research and development tax credit to provide specialist support.

   b. Develop **communities of practice** to support the implementation of Action Plans and share best practices.

   c. Develop **peer support and mentoring** through the supply chain from anchor institutions or large organisations who are described as beacons in this arena.

2. **Provide guidance to support mental wellbeing plans:**
    a. Build on the existing Mental Health at Work Commitment digital product and learn from MHPP to provide an **open-access toolkit** to support organisations.
    b. Develop a **data literacy tool** that enables organisational leads to understand what wellbeing data they already possess, and where their gaps are and provide tools to help create effective employee-level data capture to enable data-driven insights.
    c. Build on existing **best practice models of intervention** rather than building new models from scratch.
3. **Strengthen evaluation of new interventions:**
    a. Ensure all new wellbeing interventions marketed to employers have an evidence-based approach or undergo an academic evaluation at the pilot phase.
4. **Review wellbeing metric tools to meet the workplace arena:**
    a. Review the use of the EuroQol EQ5D-5L with workplace populations. It was identified that this is sub-optimal for employees in the workplace setting.
5. **Learning from the Theory of Change suggests culture change and seeing health improvement outcomes take time:**
    a. Develop longer-term research programmes to ensure sufficient time is available to understand change and its impact.
6. **Occupational Health Standards:**
    a. Develop promotion and prevention criteria within the proposed Occupational Health standards to support employers keep people at work healthier and strengthen policy and practice change.
7. **Health and Safety Executive:**
    a. Provide greater awareness for employers with psychological safety in the workplace.
    b. Provide the measures that enable employers to identify poor psychological safety in the workplace.
8. **Employers should be encouraged to support the economically inactive:**
    a. Employers should be encouraged to provide a comprehensive mental wellbeing proposition to employees as a core component of their organisational offer. This will ensure that, when individuals who are economically inactive and supported into work, the workplace they enter is psychologically safe, preventing them leaving the workplace due to psychological distress.

In conclusion, we can say that MHPP found that whilst there is heightened awareness of the importance of the workplace wellbeing agenda, organisations need more evidence-based guidance and hand holding support to implement the guidance. This is particularly relevant to SME's and micro-organisations.

MHPP may not have been able to prove a direct correlation between mental health and productivity, however it has generated significant new evidence surrounding the importance of effective policy and practice implementation and created new models of employee level interventions. MHPP has identified that organisations have gone further and faster with engagement officer support. Most importantly, MHPP found that the workplace *is* an environment where mental wellbeing prevention and promotion activities can be delivered.

MHPP has adopted a social movement approach and we believe that the interventions, activities and culture change that MHPP has initiated are transferable to other regions in the UK to see step change in workplace wellbeing in the future.
[End]