Mental Health and Productivity Pilot

FINAL REPORT

28 March 2024

Aim of this report

The aim of this report is to provide a detailed summary of the Mental Health and Productivity Pilot (MHPP) project, which started in 2019 with an award from the Midlands Engine following a budget announcement in March 2018 from the Department for Work and Pensions/Department of Health and Social Care (DWP/DHSC) Joint Work and Health Unit. The report outlines the timeline of the pilot programme over the last four years, detailing the different work-packages that were undertaken – the rationale for them and the outcomes expected; the successes; the challenges and the lessons learnt.

The final section of the report documents the overarching learning points by identifying and analysing cross-cutting themes, key impacts made, and recommendations for the future.

This final report is written in a narrative style in contrast to an academic paper, to ensure its readability for a wide audience. It references other self-contained reports and documents emanating out of the project and delivered by MHPP's different work packages and streams of work. It draws on conclusions and analysis from these reports, all of which are listed in the Appendix A and available to download as individual documents.

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1. Background and context of MHPP

In 2017, the *Thriving at Work Report*[1] was published by Lord Dennis Stevenson and Paul Farmer, having been commissioned by the then Prime Minister, Theresa May. *Thriving at Work* set out what employers could do to better support all employees, including those with mental ill health, to remain in and thrive through work.

It included a detailed analysis by Deloitte that explored the significant cost[2] of poor mental health to United Kingdom (UK) organisations and businesses and the economy. In 2017, poor mental health cost employers between £33 billion and £42 billion a year, with an annual cost to the UK economy of between £74 billion and £99 billion. It also identified that 300,000 people were leaving the workplace due to poor mental wellbeing and/or physical health conditions.

The review quantified how investing in supporting mental health at work is beneficial to businesses and other organisations and to their productivity. The most important recommendation was that all employers, regardless of size or industry, should adopt six 'mental health core standards' that lay the basic foundations for an approach to workplace mental health. It also detailed how large employers as well as the public sector could develop these standards further through a set of 'mental health enhanced standards.' The review also made a series of recommendations to Government and other bodies.

In the Spring Budget of 2018, the then Chancellor announced an award from Department of Health and Social Care (DHSC) funds to the Midlands Engine footprint, to explore the link between mental health and productivity. Following the publication of the *Thriving at Work report* in 2017, it was identified that the Midlands Engine region, with its diversity of organisations as well as a blend of urban and rural economies, had one of the lowest Gross Value Added (GVA) levels in the UK[3], thereby making it a suitable testbed for this agenda, particularly from a place-based perspective.

In February 2019, the Mental Health and Productivity Pilot (MHPP) collaboration, led by Coventry University with key partners, the University of Warwick, West Midlands Combined Authority and the mental health charity Mind, responded successfully to the tender from the Midlands Engine and were awarded the contract to undertake the programme from July 2019.

The financial and programme governance for MHPP was initiated through the Midlands Engine and included members from the Department for Work and Pensions/Department for Health and Social Care (DWP/DHSC) Joint Work and Health Unit.

Independent reviews of the MHPP programme were commissioned by the Midlands Engine in collaboration with the DWP/DHSC at the end of both MHPP1.0 and MHPP2.0. Both reports are available from Appendix B.

[1] Thriving at Work: the Stevenson/Farmer review on mental health and employers (publishing.service.gov.uk)
[2] deloitte-uk-mental-health-report-2022.pdf
[3] 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

In July 2019, the MHPP programme commenced 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

In July 2022, the MHPP was awarded an extension and additional funding to continue gathering evidence with the expectation from Midlands Engine and the DWP/DHSC to produce a final report by 31 March 2024. It was recognised that the original scope of the MHPP had pivoted due to the Covid-19 pandemic. It was also requested that a greater emphasis was put on the changes in wellbeing for employees within organisations that were undertaking the organisational level interventions such as Mental Health at Work and Thrive at Work.

2. Introduction to MHPP

The Mental Health and Productivity Pilot (MHPP) project was a multi-disciplinary partnership of more than twenty organisations, bringing together academics (including economists and policy analysts), occupational and clinical psychologists, psychiatrists, public health specialists, mental health practitioners and wellbeing service provider delivery leaders. It includes a network of leading universities, health providers, employers of all sizes, anchor institutions, organisations representing employer and employee voices, local authorities and independent sector organisations, all with the relevant skills, expertise and experience required to successfully deliver this pilot across the Midlands Engine region.

The partnership was led by Coventry University and supported by the University of Warwick, Mind nationally and sub-regionally, and the West Midlands Combined Authority. It includes a wide range of partners from across the East and West Midlands including the universities of Birmingham, Derby, Lincoln, Loughborough and Nottingham; practitioners and mental health specialists (e.g. Coventry and Warwickshire Partnership Trust, Nottinghamshire Healthcare NHS Foundation Trust); large employers (e.g. Bombardier, Jaguar Land Rover, Rolls Royce, Toyota), as well as small and medium employers and employer representation bodies (e.g. East Midlands Chamber, Federation of Small Businesses) and health systems leaders (NHS England and Improvement – Midlands Region Office for Health Improvement and Disparities (OHID) - previously, Public Health England East & West Midlands and Integrated Care Systems).

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

The partnership includes skills and knowledge from academic and clinical teams: the Centre for Business in Society and Centre for Healthcare Research at Coventry University; University of Nottingham's School of Economics and Mental Health Institute; Warwick Business School and Warwick Institute for Employment Research. Expertise includes economic assessment of the cost of productivity loss to employers due to mental health related illness; assessment of interventions that are efficacious in supporting employers and employees with mental health; and impact assessment of MHPP's interventions.

An illustration of the partners – both delivery and advisory – can be seen in Figure 1.

Figure 1: Partners

Together, the MHPP partnership has developed and tested novel interventions for employees (REST, SLEEP, BITE, MENTOR, PROWORK and Managing Minds) and amplified organisational employer-level interventions (Mental Health at Work Commitment and Thrive at Work). All the interventions have aimed to build knowledge and confidence regarding workplace wellbeing for employers, line managers and employees from both biosocial as well as business perspectives, including supporting sleep, mood regulation; disordered eating; leadership and management; job design among others

MHPP's focus has been on addressing - what is often described as - the productivity puzzle: the link between mental health at work and organisational productivity i.e., reduced absenteeism, reduced staff turnover, increased production.

3. Timeline: development to delivery

Phase 1

The first year (2019) of MHPP included a large-scale review of the national and international landscapes to investigate availability of interventions to support mental health in the workplace, including a series of workshops and interviews with organisations to understand the opportunities and challenges around workplace wellbeing.

At the same time, our partners at the University of Warwick Enterprise Research Centre (ERC) undertook a survey of c. 1,900 organisations and businesses to understand the landscape of workplace wellbeing in the Midlands. ERC has continued to undertake this survey on an annual basis (2023 saw the fourth wave) to collect longitudinal data, with the subsequent surveys funded by the Economic and Social Research Council (ESRC). The four waves of research continue to provide comparative analysis and insight.

The research undertaken, as described above, underpinned the development of MHPP's original delivery model:

- Amplification of organisational/employer-level interventions that supported organisations to achieve the *Thriving at Work* core and enhanced standards: Thrive at Work Workplace Wellbeing Accreditation Programme and Mental Health at Work Commitment.
    - Thrive at Work Workplace Wellbeing Accreditation Programme, established as a toolkit by the WMCA, includes an emphasis on the wider determinants of health focussing on - in addition to mental health, musculoskeletal, lifestyle behaviours and physical activity. Thrive at Work also promotes interventions for several protected factors, including support for employees who are affected by financial wellbeing, domestic abuse, and caring responsibilities. By working through the Thrive at Work programme, organisations can progress from an entry point Foundation level to a bronze accreditation and then proceed to silver and gold levels.
    - Mental Health at Work, curated by Mind, is a public commitment that organisations can make, to work towards the Thriving at Work core standards as a minimum. The Mental Health at Work website gives organisations access to an extensive range of workplace wellbeing resources as well as signposting to further support.
- Piloting of employee level novel interventions: MENTOR, PROWORK, Managing Minds, Sleep, Bite and REST.

Covid-19 Pandemic

In March 2020 the Covid-19 pandemic hit and changed the way that organisations across the UK operated, consequently impacting on the ability of MHPP to fully reach its original intent. The pandemic resulted in a heightened demand for workplace mental wellbeing support but, paradoxically, MHPP saw a reduced take up of the existing workplace level interventions - Thrive at Work and Mental Health at Work Commitment - as organisations and businesses were focussed on day-to-day delivery and/or on simply endeavouring to maintain viability. MHPP's ability to recruit employees to take part in the research pilots proved difficult too following the onset of the pandemic.

However, rather than pausing the existing programme when the pandemic hit, MHPP - in consultation with Midlands Engine - pivoted to support organisations and businesses by providing additional support and guidance to employers and employees in the new circumstances. Home working and the demands on key workers created an environment where communication between workplaces and employees appeared to have become stifled; and the stigma of mental health in the workplace and the increased nervousness of furloughed employees resulted in a reduced willingness to disclose mental health issues.

MHPP, underpinned by an integrated engagement and communications strategy, adapted and developed new programmes and delivery methods to meet these emerging demands and needs within the region. Increasing levels of anxiety and a rise in the demands for early mental health support, led to adaptations of the academic interventions, too: REST was developed, and inclusion criteria were expanded to include those with clinical level symptoms in the REST and SLEEP pilot interventions.

Other new aspects of MHPP were developed and communicated widely with organisations and individuals in response to the pandemic:

- *Thrive at Home* was established to support managers and people who were adapting to a new way of working.
- Modules on managing stress and resilience were adapted from partner university courses and delivered as bitesize online sessions.
- 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). *Bridge the Gap, Start a Chat* focussed on encouraging open conversations at work about mental health, and provided employees, managers and organisations with advice and tools to do so. This campaign also acted as a lead generation tool to drive awareness and engagement with MHPP's core interventions.
- 'Bridge the Gap, Start a Chat', had a high proportion of reach in both the construction sector and with men aged 24-55yrs, both historically considered as 'hard to access' areas.
- Post-pandemic 'normality' gradually resumed in 2022, and by that time MHPP had reached over 700 organisations and businesses in the Midlands region with a reach of approximately 600,000 employees.

Despite this, the depth of evidence that had been envisaged to be generated when MHPP was first commissioned, was not apparent, due to several factors, not least the onset of the Covid-19 pandemic. Other factors included

- a one-size-fits-all approach (for workplace wellbeing interventions) was not appropriate particularly for small and medium enterprises.
- interventions take time and effort to implement.
- whilst the academic interventions captured robust data at baseline and post intervention stages; the same - especially quantitative data - proved challenging to be captured from the organisational interventions.

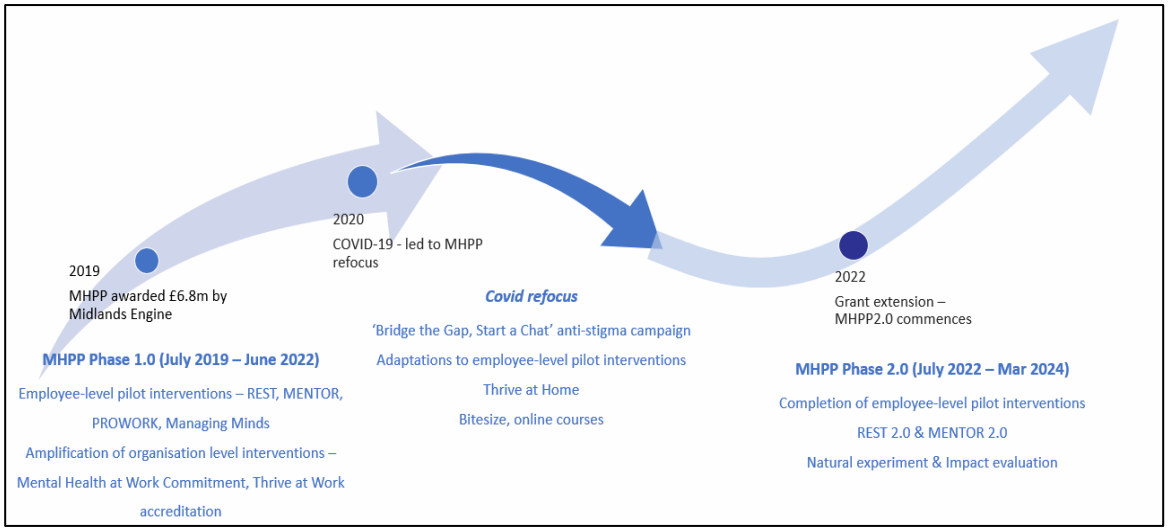
Phase 2 (MHPP 2.0)

Considering this, and to strengthen the evidence base, MHPP was awarded additional funds in July 2022 to continue with the programme until March 2024, with the following additional aims:

- To develop a universal set of minimum data variables, founded on robust academic methodology, that enable baseline and post-intervention data collection and data analysis across all interventions.
- To target engagement and promotion to suit organisations of different types (including different sizes, different sectors and from different locations).
- To provide individualised support to organisations who do not currently have a strong understanding of their workplace mental health and wellbeing needs. This was key since organisations were more likely to engage when they have this understanding.

This phase - MHPP2.0 - commenced towards the latter half of 2022 and included a natural experiment known as the MHPP 'Enhanced Offer', as well as further amplification of the organisational interventions and further testing of the academic interventions.

Figure 2: timeline of MHPP from 2019 to 2024



Engagement and communications were key enablers in this phase based on the learning from the previous phases. Continuous messaging, awareness raising, relationship maintenance and presence in the wider ecosystem ensured that key participants and audiences were discovered, supported and engaged. It also allowed for economies of effort and scale, where we joined 'forces' with other agents working in this space. Sharing experiences, resources and learnings made collaboration and co-production easier, thus saving time and money or enhancing the overall outcomes.

By the end of the four years, MHPP provided significant support to over 1130 organisations, reaching over 800,000 employees in the Midlands region.

4. Engagement and communications

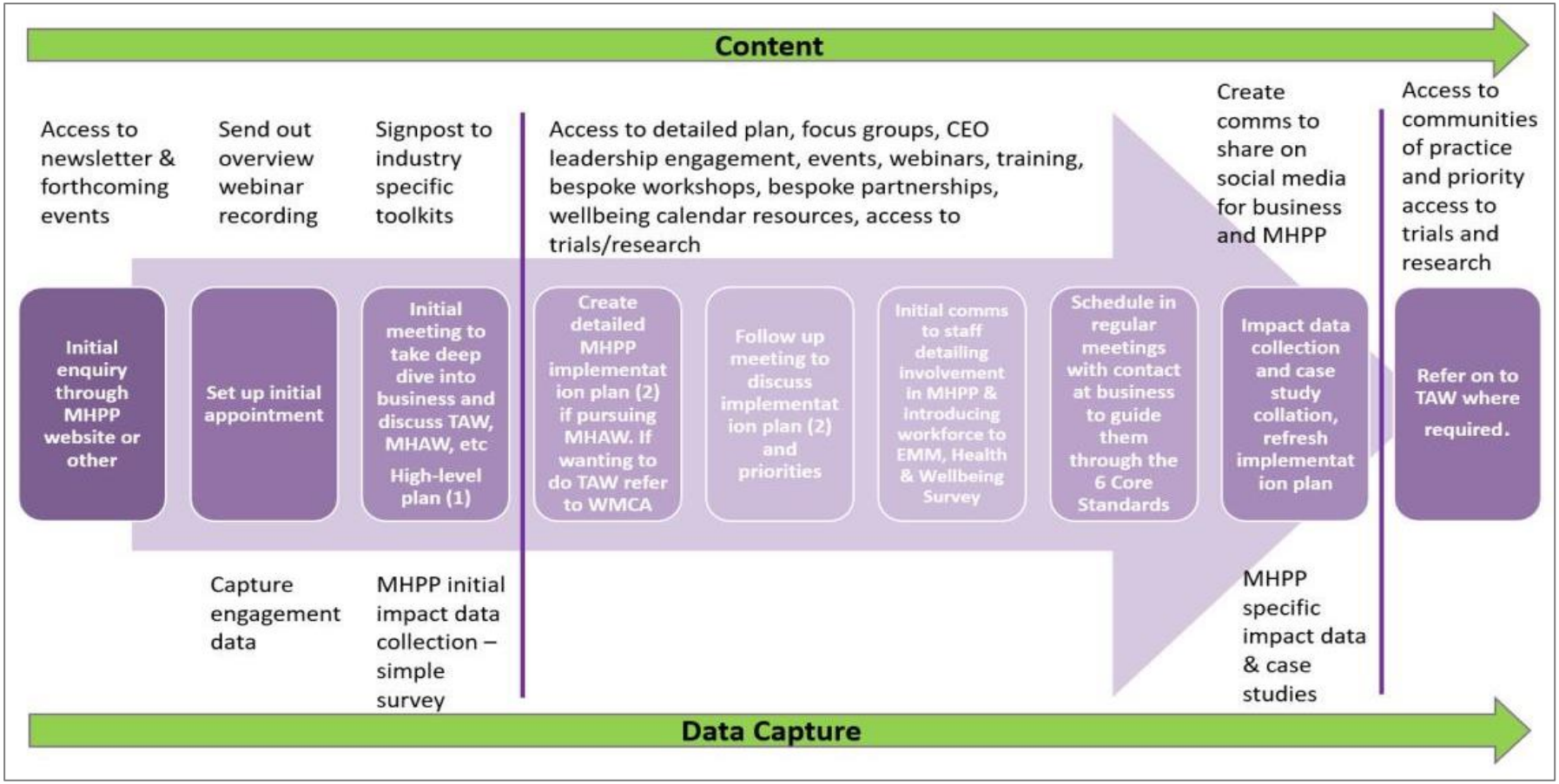
An engagement and communications strategy has remained a key enabler of MHPP's delivery from the outset and led to the creation of distinct and targeted messages and support for employers and employees. The approach addressed the objectives at the time and was founded on the following strategies and frameworks:

- The messaging strategy was founded on the COM-B framework (Capability, Opportunity, Motivation) to understand audience behaviours, drivers and motivations, which resulted in a messaging framework using audience segmentation strategies and product analysis to map MHPP products to relevant audience segments
- Stakeholder analysis framework to identify and engage with a diverse range of regional stakeholders including:
    - Networks of partner universities: Birmingham, Coventry Derby, Lincoln, Loughborough, Nottingham and Warwick.
    - Practitioners and mental health specialists: Coventry and Warwickshire Partnership Trust, Nottinghamshire Healthcare NHS Foundation Trust.
    - Large employers such as Bombardier, Jaguar Land Rover, Rolls Royce, as well as SMEs
    - Employer representation bodies such as the East Midlands Chamber, Federation of Small Businesses.
    - Health systems leaders - NHS England and Improvement – Midlands Region; Office for Health Improvements and Disparities (OHID) - previously, Public Health England, East & West Midlands and Integrated Care Systems.
    - Local authorities and the West Midlands Combined Authority.
    - ACAS
    - Health and Safety Executive
- Co-creation strategy involving Midlands employers from a variety of sectors and geographies as well as employees with lived experience of mental health problems who helped develop campaigns and content.

Key examples of engagement and communications:

- Roll out of a series of robust/evidence informed tools to deliver workplace wellbeing agendas that included Thrive at Work and Mental Health at Work as well as Oscar Kilo, Every Mind Matters, Mental Health First Aid, and This is Me.
- Rapid development of additional support and guidance for employers and employees during the Covid-19 pandemic, to address the needs for workforce mental health support during challenging and unfamiliar times. This included the development of *Thrive at Home*, a new online platform with advice and signposting for employees and line managers to support them with the new ways of working and challenges that people were facing.
- Development of an employer journey for the Enhanced Offer as shown in Figure 3. This aimed to maximise engagement and guide businesses through their wellbeing journey, including a bespoke plan that was reflective of their industry, workforce and wellbeing needs. It involved initial meetings with each business to take a deep dive into the wellbeing provision offered, sickness and absence information, gaps in provision, and goals for their workforce. From this overview, businesses were then supported to undertake a health and wellbeing survey to ascertain baseline data from their workforce and to identify key themes where staff felt they needed additional support.

Figure 3: Natural Experiment/ Enhanced Offer employer journey



- Campaign development using online and offline channels to target specific audience groups with key messages, signposting and calls to action. Snapshots of the campaigns are shown in Figure 4. These include:
  - '*Bridge the Gap, Start a Chat*' (2021) - awareness raising and stigma reduction campaign, which reached over 2 million people; with more than 1000 people downloading the Employer Resource Pack materials and continuing to do so as the resources are evergreen and can be used again and again.
  - '*MHPP Journey – Get on Board*' (2022-23) – this was a lead generation campaign for the natural experiment/ Enhanced Offer to organisations. It included an added call to action on every page of the website and marketing tools, to make it easy for employers to sign up and find out more about the MHPP journey and the Enhanced Offer.

Figure 4: 'Bridge the Gap, Start a Chat' (2021); (top); 'MHPP Journey – Get on Board' (2022-23) (bottom)

Conclusions and recommendations from engagement and communications

- Engagement and communication remain key enablers and should be funded and appropriately resourced (human and digital) from the outset.
- Agility was key when balancing the needs and objectives of research projects and the priorities and wants of employers. Not all organisations/employers are 'research-ready'. The complexities and instabilities in an organisation's 'working day' result in competition for resources, and activities seen to have longer-term benefits/impact are often not given high priority. Engagement and relationship management helps to build trust and to support organisations, but project timescales need to be cognisant of competing priorities. Strong inter-personal relationships can certainly help alleviate issues here, but building these relationships take time.
- Audience segmentation was essential and additional thought and resource need to be allocated to create strong USPs and messaging for each sector, geography and stage of adoption. Once audience segmentation was clear, targeted paid social media continued to provide positive results, for example the media activity for 'Start a Chat' campaign contributed to a campaign reach of 2 million people and 8,352 new web site users.
- Linguistic or descriptive choices are critical to supporting communications and engagement activities to 'land' in the specific audience segments. For example, at the start of Phase One work, many in the geographical East-Midlands found it difficult to connect with the West Midlands Combined Authority, seeing no representation of themselves.
- Co-production with employers, employees and people with lived experience has generated important and significant feedback and improved the credibility for the programme. It would be beneficial to include this philosophy across all programmes. Full partnership buy-in for campaign objectives and 'goals' was crucial to overall success. Any similar programme would benefit from having the voices of those with lived experience fully embedded in decision making and broader governance from the start.
- The Enhanced Offer was time and resource intensive, leading to future sustainability questions and the Time to Change Employer pledge closed for similar reasons. There was a fine balance here though as many employers (and therefore individuals and the economy) have benefitted from the support provided as part of the offer. Investment will continue to be a key challenge, but additional work was essential to identify the 'sweet spot' between investment and impact.
- Future activities that sparked interest among employers were those that offered support to evaluate the impact of initiatives/work internally, more events within their organisations and support getting buy in and sharing best practice.
- Social media planning and monitoring was time consuming but extremely effective to continue to build and maintain relationships, rather than it simply being a 'comms' tool.
- Changing the culture of an organisation and attitudes within organisations takes time. There are no quick fixes here. The MHPP approach has been labour intensive. However, this is what has had the impact. Organisations have given feedback that they like the "hand holding" approach, the guidance and accountability. Organisations have formed supportive relationships with their engagement leads and through these communities of practice, they have extended their support network, which has helped them to drive this agenda forward within their own organisation.
- Health and wellbeing cannot be a tick-box exercise. There was not a "one size fits all" approach and this requires both culture and attitude change in organisations. Organisations that took part in MHPP explained the importance of holistic approaches to workplace mental wellbeing, and the improvements when they were steered away from purely reactive approaches for example., delivering training for managers in response to a grievance process, or providing counselling services at year end when work levels were too extreme for the staff, rather than dealing with work place demands earlier. Through the qualitative interviews our evidence suggested that whilst improvement can be achieved by leaving an organisation with a framework to work through on its

own, organisations who are supported feel more able, and can achieve the outcome faster with this support. Investment is the difference between making sustainable change as opposed to a temporary fix.

A detailed reports on Engagement and Communications can be found in Appendix A (Document A).

5. Delivery and impact

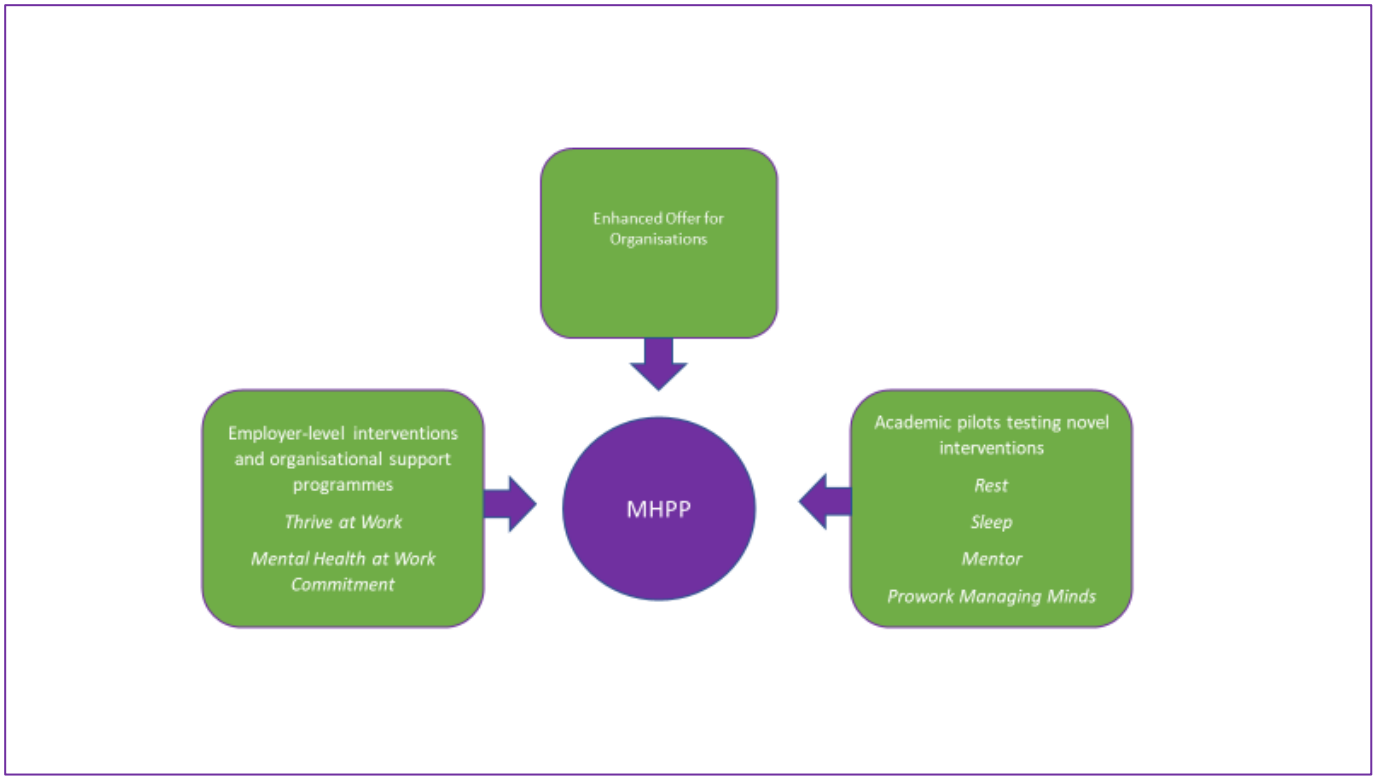
The delivery of MHPP took place across two key phases. MHPP 1.0 included the delivery of a free support offer to organisations to help them enhance their mental wellbeing approaches. Working with Mind and the West Midlands Combined Authority, Midland's organisations were able to access two free interventions. In addition, following several literature reviews and forums with organisational leads and employees, a set of novel workplace pilot trials to support employees to remain mentally well in the workplace were developed.

As such, MHPP's delivery can be summarised as:

- Amplification of existing employer-level interventions and organisational support programmes, namely:
    - Mental Health at Work Commitment
    - Thrive at Work Wellbeing Accreditation Programme
- An Enhanced Offer, evaluated through a natural experiment
- Academic pilots testing novel interventions aimed at providing employee-level and line manager training and interventions, both individually and jointly.

It was recognised during MHPP1.0, that delivery of the Mental Health at Work Commitment and Thrive at Work Accreditation was not capturing relevant data to test whether these interventions were making a difference to employee's mental wellbeing. The Enhanced Offer was created as part of MHPP 2.0 to address this gap.

Figure 5: Components of MHPP



5.1 Existing employer-level interventions and organisational support programmes

Organisations operating in the Midlands region were invited to start their workplace wellbeing journey with either the Mental Health at Work Commitment and/or Thrive at Work. Both interventions were provided as a free offer to any organisation wishing to take part and were aimed at supporting organisations to improve their workplace mental wellbeing offer.

An overview of activities and impact are briefly summarised below. Full reports can be found in Appendix A (Documents B, C and D).

5.1.1 Mental Health at Work Commitment

The Mental Health at Work (MHAW) programme was launched nationally in 2018 to support the Stevenson Farmer (2017) recommendations. Curated by Mind, the MHAW website made navigating the mental health landscape easy through original content and a curated database of over 570 resources from a wide range of providers.

Built on the Thriving at Work standards, MHAW launched in October 2019, as a simple framework for organisations to improve and support the mental health of their people. It was deliberately digital, light touch in terms of people resource and scalable, and it formed a core part of MHPP's amplification of workplace wellbeing interventions in the Midlands Engine region.

MHAW was offered free to organisations across the Midlands. It continued to operate at a national level but amplification across the Midlands was enhanced by the MHPP programme. All organisations were invited to sign up to the Mental Health at Work (MHAW) Commitment.

The Mental Health at Work website will close in June 2024. However, organisations can still sign up to and implement the Mental Health at Work Commitment. After June, all relevant and supporting documents and resources to implement the Commitment and its standards will be accessible via the Mind website.

The following section provides an overview of the national Mental Health at Work (MHAW) research findings.

Summary of main points from reports, research and activity

- According to the Mental Health at Work quantitative survey in 2023[4], signalling to employees that their mental health is important was the highest driver for signing the Mental Health at Work Commitment regardless of organisation size. This was consistent with the results found in the Mental Health at Work survey undertaken in 2021. However, signalling to prospective employees had moved up into second highest – in 2021 it was the lowest driver, indicating that recruitment of new talent into the organisation is now seen as an important reason to change mental health practices and be transparent about doing so.
- Across the national footprint across all sizes of employers, MHAW signatories felt more capable of achieving the MHAWC standards than in 2021. The biggest change was seen in small and micro sized organisations with much higher number feeling capable (+6%) and fewer organisations feeling incapable of achieving the MHAWC (-10%). We attribute this to the large focus for MHAW over the last 2 years on producing content and support specific to SMEs.

[4] MHAW survey 2023

- Results of the Mental Health at Work quantitative survey in 2023[5] show that considerably more employers are undertaking action indicators (a set of 32 actions that identify what organisations can do to achieve the Core Standards) under 5 out of 6 of the standards than in 2021 – the number of organisations achieving 30/32 action indicators had improved. Differences varied from +17% to +67% with more employers doing those activities than 2 years ago. The only exception to this is for Standard 6 (transparency & accountability through reporting) where significantly less organisations were undertaking activity than 2 years ago.
    - In terms of feelings of capability to deliver each individual standard, results indicated that **Midland's signatories felt less capable of delivering standard 3** around promoting an open culture (95% vs 100%) and slightly **more capable of delivering standard 6** (85% vs 81%). This finding around standard 6 matches the improved outcomes for data collection and use for Midland's signatories (see below).
    - In terms of measuring mental health and using data to inform practice, **Midlands organisations were more likely to understand the tools** available that measure workplace mental health (80% Midlands; 71% National; 70% outside Midlands), **more likely to regularly collect data and feel they had the expertise to analyse it** than non-Midland's areas (collect: 75% Midlands; 74% National; 68% outside Midlands; analyse: 70% Midlands; 71% National; 62% outside Midlands)
    - **Midlands based signatories were much more likely to use collected data to inform their plans** and activities than all other areas (90% Midlands; 63% National; 77% outside Midlands). This matches the capability ratings around standard 6, detailed above. These findings on differences in mental health data collection and use are highly likely due to the presence of MHPP in the Midlands area particularly focusing on this area of policy and practice change.
- When assessing action indicators against time signed up to MHAW Commitment, we found a general trend between 0 and 2 years where activities increase steadily across most indicators. At 2 years some activities show a plateau and 3+ years a drop in the number of employers still undertaking some of those activities. This shows the importance of continuing to work with employers to maintain momentum over long periods and that it isn't just new employers to the agenda that need support.
- In the qualitative interviews, employers noted how the Commitment had facilitated their knowledge and confidence in supporting the mental wellbeing of their employees. Not only did the Commitment help affirm the positive steps they had taken to improve staff wellbeing, but it also highlighted areas for improvement. Furthermore, the Commitment was valued for keeping mental health at the forefront of the organisations' priorities.
- Employers who have been on the MHAW Commitment journey the longest are more likely to feel positive about their culture. Interestingly, the smaller the organisation, the more likely they were to feel positive about their culture, showing that larger organisations may feel they need to work harder to achieve a positive mental health culture.
- When analysing the Mental Health at Work quantitative survey in 2023[6] , those in the Midlands felt they had more capacity to implement actions to improve staff mental wellbeing than other areas (100% Midlands; 91% National; 91% outside Midlands). This may be due to increased support from MHPP engagement officers[7].

[5] *Ibid.*

[6] *Ibid*

[7] MHPP engagement officers (EOs) provided one to one support to organisations signed up to the MHAW Commitment or Thrive at Work Accreditation. The EO provided what is later described as handholding for the organisation to provided support and experience to help the organisation navigate the mental wellbeing agenda.

- Whilst confidence that they can produce/have produced an achievable Mental Health at Work action plan[8] was very similar across areas, a higher proportion of Midlands signatories felt confident in their ability to implement their plan (95% Midlands; 80% National; 89% outside Midlands). Those with national coverage were much less confident in their ability to achieve their plan and understood less, the services available to them as an employer to do so (90% Midlands; 74% National; 85% outside Midlands)
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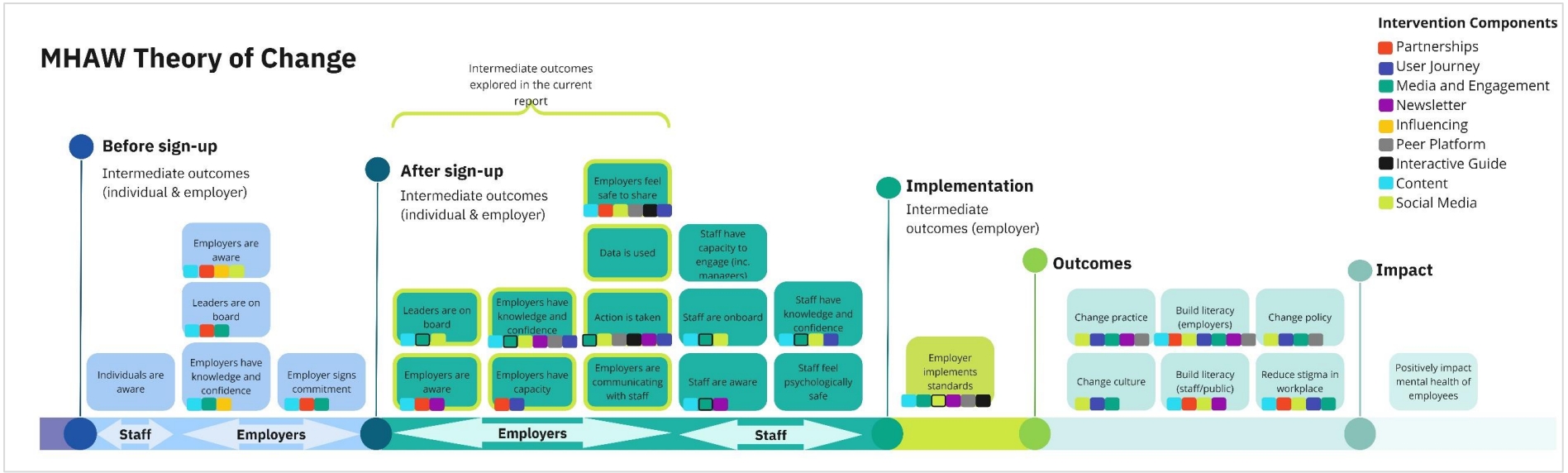
TTK Confectionery (SME): *"Signing up to the Mental Health at Work Commitment has made us more confident as a business in speaking up about mental health. It's really important we take this seriously, and the Commitment has got us all thinking about how we can improve things at TTK Confectionery.*
Our staff have responded very well – many have done the NHS 'Every Mind Matters' quiz and have been using the strategies it has recommended for them. The mental health champions we've trained are also doing an excellent

Summary of key adaptations

- In the course of time working alongside MHPP, Mind have created a number of new products launched to support employers to work towards the Mental Health at Work Commitment: a peer platform tool; an interactive guide which helps employers write a tailored action plan and find relevant resources; an automated email user journey; and many more individual resources for those most in need.
- New research of the journey for mental health outcomes within an organisational setting was undertaken in 2022 by Mind and the Mental Health at Work Commitment team. This focused on the needs of micro business owners and self-employed people and led to the development and launch of a new mental health digital information hub[9] to support organisations. Further research undertaken by the University of Warwick led to the creation of a new Mental Health at Work Theory of Change model, which can be viewed as Figure 6. The research gathered qualitative evidence from employers and employees, which led to the strengthening of impact measures the aim of which was to assist organisations to implement an effective mental wellbeing offer in the workplace.

[8] Mental Health at Work action plans templates were shared with commitment signatories to enable them to shape an action plan within their organisation.
[9] Support for small businesses in partnership with Simply Business – Mental Health At Work

Figure 6: MHAW Theory of Change and Intermediary Outcomes – developed in partnership with University of Warwick[10]



[10] For a larger image, please refer to Appendix A (Document C)

Impact

The overarching impact and legacy of the Mental Health at Work programme is that 3000+ organisations and leaders have committed to prioritise MHAW nationally, with 650 in the Midlands Engine region. These leaders now have the tools and resources to drive change in their workplaces. Findings[11] also demonstrate that the MHAW Commitment is not just a tick box exercise. We have seen significant improvements in organisational confidence, capability and activity within Commitment signatories compared to research completed two years ago and clear indications that the longer organisations are following the Commitment, the more likely they are to achieve mental health policy and practice changes.

MHAW is reaching intermediate outcomes as part of the Theory of Change as evidenced in the Mental Health at Work Academic Evaluation Report - we can say that change and impact is happening. Therefore, based on this Theory of Change we can anticipate a resultant change in employee outcomes over time.

Topics for further research and support programmes

Future programmes should strive to be appropriately resourced to enable longitudinal assessments of new Commitment signatories to understand whether the policy and practice changes we know are possible through the MHAW programme, do result in changes in employee outcomes. Based on our quantitative findings, where activity increases across all Commitment standards for at least 2 years, before seeing a plateau or slight drop, we would recommend that these longitudinal assessments of employee outcomes take place over 2–3-year period to give enough time for practice and culture changes to see a resultant affect.

Micro-organisations consistently reported lower levels of confidence and capability, indicating that more focus on the very smallest of employers and how to support them should be an aim of future programmes of work.

Employers need significantly more support to navigate how to measure mental health and whether their interventions are having an impact, as well as how to put this insight into practice. Ways to encourage more transparent sharing of organisational progress in this area internally and externally is an essential area of future work. How to engage employees directly in moving forward practice and culture was also an area of need and should be a focus in further support programmes.

5.1.2 Thrive at Work

Thrive at Work is an employer accreditation programme focused on workforce wellbeing. Its team of advisors support local/regional employers to implement and/or improve their policies, procedures and offers to support the health and wellbeing of their workforces, thereby protecting and enhancing their organisation's productivity. The Thrive at Work programme was designed and implemented by the West Midlands Combined Authority (WMCA) following the WMCA's inception and its first Mental Health Commission. Beginning as a trial to explore a 'fiscal incentive' for employers implementing improved health and wellbeing measures for their workplaces, Thrive at Work then transitioned into MHPP 1.0 as one of its 'established' products, and subsequently into MHPP 2.0.

It was initially designed with public health intelligence and support, primarily as a way to bring into perspective, the role of wider determinants of health – in particular highlighting to a business audience, employment/working conditions as a key determinant. Thrive at Work has increasingly engaged with business support services more directly, emphasising how the enhancement of the health and wellbeing of workforces makes good business sense.

[11] MHAW survey 2023

There are a number of reasons for this: partly the economic climate described above and increased traction with business; partly due to learning from other delivery and local colleagues, as a result of internal organisational restructuring (i.e. closer to economy / productivity-focused areas of work, and slightly further from the traditional health and wellbeing base); and partly due to external restructuring, namely the integration of Local Enterprise Partnerships into Local and Mayoral Combined Authorities, including across the (West) Midlands where Thrive at Work is hosted.

The original programme (MHPP 1.0) had three levels of award: Bronze, Silver and Gold. Through employer feedback it was highlighted that there was an opportunity to make the offer more succinct and achievable in the early phases, so a Foundation Level was designed and introduced. It was calculated that Foundation Level could be achieved in 90 days, giving an organisation a tangible goal to aim for and an opportunity for recognition earlier on in the process. This has made the programme more attractive to smaller organisations and those at the start of their wellbeing journey, who previously found it to be out of reach. It also led to a quicker journey through the bronze level, averaging 7.5 months, hence within 12 months an organisation can feasibly achieve two out of the four levels.

Thrive at Work can clearly demonstrate its foundation in evidence based good practice and can be promoted as a trusted partner - unique selling points when promoting the programme and in the early conversations before registration. Anecdotally, there has been a real impact felt by the organisations who have benefited from a structured framework approach which has made improvements to data collection and monitoring within a company. Although this is positive, the programme learnt that to measure impact in a meaningful way it was being undertaken as a manual task and whilst the impact was there, it was very difficult to report on. Therefore, it was imperative that Thrive at Work fed into Enhanced Offer baseline data collection to be able to enhance their reporting and measure success. The Thrive at Work team utilised free resources to engage, promote and raise its awareness through focused engagement in all geographical areas of the Midlands region, ensuring signposting was to trusted peer reviewed resources, further adding to the evidence base foundation of Thrive.

One of the enduring strengths of Thrive at Work, as demonstrated by sign up data, is its function of recognizing employers' efforts and achievements in this space. For example, "we care greatly about our team and want to shout about our efforts". The journey to Thrive at Work accreditation is, for most participants, a challenging one to complete because its framework of criteria is comprehensive and rigorous, which means that the achievement feels valuable and worthy of its public recognition. In this vein, the Thrive at Work Awards ceremony is a significant marker in the calendar, and a chance for the Mayor of the West Midlands to join in celebrating the good business of the region (and wider). During MHPP 2.0, the 2022 Thrive at Work Awards event was a tangible success not least for the 53 organizations receiving their accreditation awards but also for raising the profile of the Thrive at Work accreditation as an achievement supported by the Mayor, encouraging others to join the journey, as described by the two quotes below:

Cllr Izzi Seccombe, Leader of Warwickshire County Council & WMCA Portfolio Lead for Wellbeing: "T*he Thrive at Work Wellbeing Commitment is a standard of good practice and a quality mark for health and wellbeing in work. You should all be beaming with pride about what you've achieved: you're demonstrating that you are truly committed to the health and wellbeing of your staff, and that your organisation stands out from the crowd as an 'employer of choice'. You have all invested in the wider health of your people and the Thrive at Work Commitment framework has enabled you to bring everything together within your mental health and wellbeing strategies. Your support in helping your staff to get regular exercise, eat healthily and manage stress – to name but a few of the many things you're doing – can help them profoundly. What we perhaps haven't yet championed loudly enough is the resilience this builds in individuals and the wider workforce: supporting a 'prevention rather than cure' approach, as our workplaces are such key drivers of our overall health*.

Andy Street, Mayor of West Midlands Combined Authority: "*The West Midlands Combined Authority are committed to assisting employers to create working environments which, not only enable more people to be in work, but also improve business performance and employee wellbeing. The Thrive at Work Wellbeing Commitment is a standard of good practice and a quality mark for health and wellbeing in work. You should all be beaming with pride about what you've achieved: you're demonstrating that you are truly committed to the health and wellbeing of your staff, and that your organisation stands out from the crowd as an 'employer of choice'. You have all invested in the wider health of your people and the Thrive at Work Commitment framework has enabled you to bring everything together within your mental health and wellbeing strategies."*

The Thrive at Work Accreditation (TAW) intervention was provided free of charge, to organisations within the Midlands throughout both phases of MHPP. In MHPP1.0, the intervention was provided as a holistic workplace population level intervention which guided employers to good practice approaches including creating a health needs assessment and action plan, but. It was not set up to capture individual level employee mental health outcomes. For MHPP2.0, amplification of TAW continued. Several organisations who signed up to TAW, also signed up to take part in the MHPP Enhanced Offer. This enabled a robust data collection process to be undertaken and supported further review of the TAW data collection process.

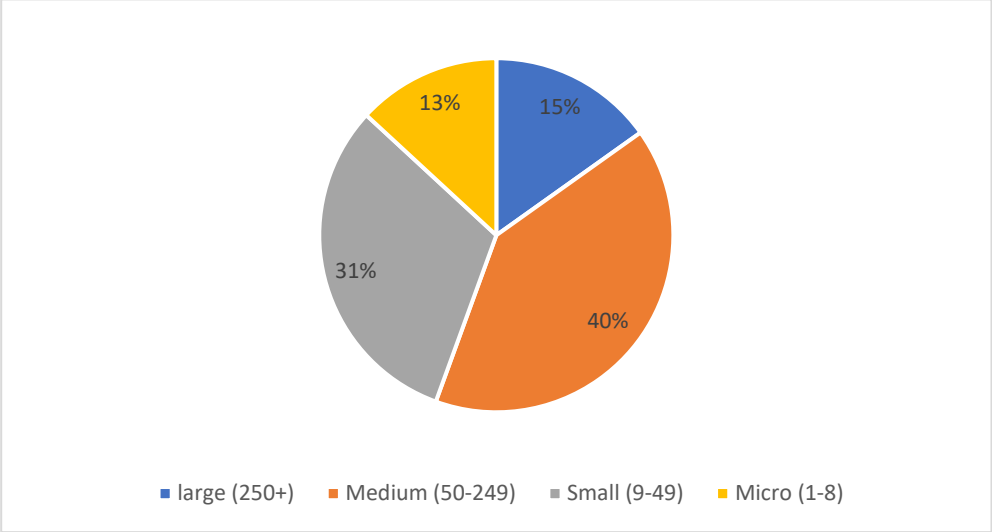
Summary of main points

- During the time the Thrive at Work programme has been part of MHPP 2.0, it has evolved its operational structure to take a more geographically based and 'account management' approach. As operations evolved, it branched into two specialisms: engagement and accreditation; and more recently, it has implemented a more 'account management' approach that sees client supported from engagement stage right through to accreditation. Relatedly, the Thrive at Work programme has recently (through MHPP 2.0) grappled with its primary purpose as one of consultancy support over accreditation compliance.
- The programme has repeatedly demonstrated that it responds to an overt need. Previously, it may have been seen as a 'nice-to-have' for those that recognised that they needed support, whereas the more recent post-Covid economic climate underlines the need to understand health and work as interdependently linked. As such, the programme has benefitted from closer collaboration with business support mechanisms and concomitant recognition.
- As it moves into its future guise, the Thrive at Work programme will use its learnings from engagement in MHPP 2.0 to better capture data at the outset and subsequently evaluate its impact as well as to modernise its content and ability to adapt.

Impact

- The Thrive at Work programme has primarily supported SMEs as can be seen in Figure 7. This aligns with its original aims and design. Larger organisations often have their policies, procedures and offers in place, whereas micro-organisations and businesses can find it less beneficial to implement specific processes although they welcome the improved understanding of the relationship between work and health.

Figure 7: Thrive at Work proportion of signups by size of organisations operating within MHPP



- Most SMEs that undertake the Thrive at Work programme are starting with minimal previous engagement in this space. They welcome the guidance of the Thrive at Work framework; they can tangibly evidence the difference made and they value the recognition of accreditation.
- As demonstrated through the collation of evidence for accreditation, not least the staff survey, those organisations that take on board the breadth and comprehensiveness of the programme feel a significant impact across their organisations.

Millennium Point, Vanessa Currie: *"Thrive at Work is a very well-structured simple programme to follow. The work you put in more than surpasses what you get back with improvements in health and wellbeing,*

Solihull Metropolitan Borough Council: *"The Thrive at Work programme gives you something to aim for, keeping you focused and pointing you in the right direction. Achieving accreditation of the award sends out a message to staff and external clients as being an employer of choice."*

5.2 Natural experiment of the Enhanced Offer to organisations

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. However, there was limited employee level data capture, in part due to previous resourcing structures. This meant it was difficult to identify whether the organisational level interventions were impacting on individual health outcomes of employees. 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.

A natural experiment is an investigative approach where events, interventions or policies are not under the control of researchers but are amenable to research which uses the variation in exposure that they generate to analyse their impact. Natural experimental studies are thus methodological approaches to evaluating the impact on health or other outcomes of such events.

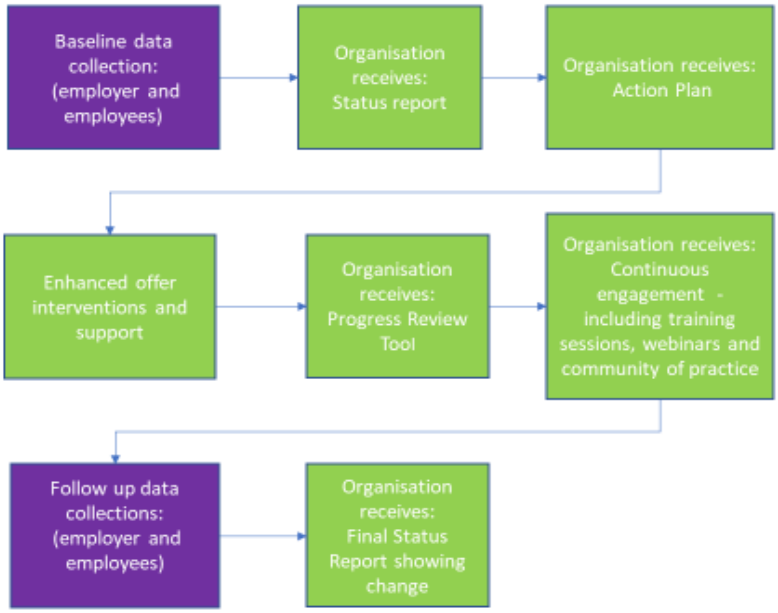
MHPP's natural experiment evaluated the Enhanced Offer to organisations (including interventions such as: status reporting; action planning; continuous engagement and other support already evident within the delivery of both Thrive at Work and the MHAW Commitment). As part of the natural experiment, data was collected (both quantitative and qualitative) from employers and employees at two time points, to investigate the association of change in employee mental health, absenteeism, presenteeism taking part in the enhanced offer.

The study sample contained a mix of large, medium, small and micro-organisations working across multiple sectors including but not exclusively, public sector, health, education, manufacturing, professional services, transport, retail and hospitality and voluntary sector.

A full report on the Natural Experiment can be found in Appendix A (Document E).

Figure 8 depicts the Enhanced Offer with data collection points of the natural experiment.

Figure 8: Enhanced Offer (green) with data collection points of the natural experiment (purple)



Objectives

- To assess change over time of mental health in employees; absenteeism and presenteeism in organisations participating in MHPP.
- To investigate differences in the above outcomes between those taking part in varying levels of MHPP.
- To conduct a return-on-investment analysis from an organisational perspective estimating the cost-effectiveness of the programme by evaluating the health-related quality of life (HRQoL) gained per unit of expenditure on each level of the programme.
- To explore employer and employee experiences of addressing mental health in at varying levels in the workplace
- To explore consistencies between qualitative and quantitative data to enable a fuller exploration of the MHPP programme across the natural experiment.

Methods

The research programme undertook a natural experiment with embedded qualitative studies[12].

The key features of these definitions are that (1) the intervention is not undertaken for the purposes of research, and (2) the variation in exposure and outcomes is analysed using methods that attempt to make causal inferences (Craig *et al.* 2012). It is essential – when developing a robust and useful evidence base for policy – to use a range of methods to estimate the effects of interventions not under researchers' control and to understand how, where, and for whom those effects are realised for (Hanckel *et al.* 2021).

Quantitative data on the characteristics of participating organisations (e.g., organisation size, turnover, profession) were collected at baseline via a facilitated questionnaire during a meeting between the organisation and research personnel. Questions around existing workplace wellbeing practices were collected at baseline and after six months. In addition, organisation 'wellbeing leads' were invited to register their interest in taking part in an interview exploring their experiences of MHPP in their organisation.

Quantitative data on employee characteristics and outcome measures described below were collected at baseline and after six months via an online survey which was sent out by their employing organisations. At the end of the employee survey participants were invited to register their interest in taking part in an interview.

These interviews formed the embedded qualitative study of the Natural Experiment, exploring employees and employing organisation's perception of mental health and wellbeing in the workplace, the perspective of engagement officers who delivered interventions in a range of organisations, was also captured. Participants were purposively sampled to represent a range of initiatives and timepoints of implementation.

The topic guides for the embedded qualitative studies were informed by the Theoretical Domains Framework (TDF) version 2 (TDFV2) (Cane et al., 2012). The TDF is an internationally recognised theoretical framework that provides a theoretical lens through which to view the cognitive, affective, social and environmental influences on behaviour (Atkins et al., 2017). Whilst primarily developed for use in implementation research, it is widely adopted for use in process evaluations and is appropriate for use within this natural experiment, as it will identify the key influences on accessing and supporting mental health in the workplace. The TDFV2 integrates 128 theoretical constructs from 33 theories into 14 domains (Atkins et al., 2017). The domains enable specific exploration of where barriers and enablers are and how to promote or change these with appropriate evidence-based behaviour change techniques.

The interview guide provided a useful prompt for discussions with interviewees about the perceived facilitators, barriers, and opportunities of implementing mental health and wellbeing strategies of MHPP interventions in their respective organisations. To ensure an in-depth inquiry, questions addressed all 14 TDF domains. The interview guide was piloted to confirm comprehension and question organisation. Interviews lasted between 45 to 90 minutes with interviewees actively engaged in the process and the discussion of the topics.

[12] A natural experiments approach means investigation of events, interventions or policies which are not under the control of researchers but are amenable to research which uses the variation in exposure that they generate to analyse their impact. Natural experimental studies are thus methodological approaches to evaluating the impact on health or other outcomes of such events.

Study setting and recruitment

Employing organisations across the Midlands were invited to engage with MHPP through a communications campaign directing them to the MHPP website (https://mhpp.me). The website provided all the participant information and invited employers to consent to take part in MHPP. Employers provided their contact details and were contacted by an 'engagement officer' who met them virtually or face-to-to start them on their MHPP journey. This contained the following steps:

- Initial meeting to outline the MHPP intervention and natural experiment.
- Baseline meeting with employing organisation incorporated facilitated questionnaire to collect data on organisational characteristics and current workplace wellbeing practices.
- Employing organisation sent a link for employees to complete survey on employee characteristics and outcome measures.
- Employing organisation participates in an MHPP intervention (described below). This includes receipt of a report based on their current workplace practices with recommendations and the creation of a bespoke organisational action plan.
- Organisations chose whether they took part in the low, medium or high-level MHPP intervention (described below).
- After 6 months follow-up data was collected on workplace wellbeing practices implemented. This in informed a second report presented to organisations.
- After 6 months the employing organisation sent a link for employees to complete a follow-up survey on outcome measures.

MHPP Enhanced Offer Interventions

Employing organisations could choose from three levels of intervention or none. The three levels were based on the level of engagement time provided by the programme Engagement Officers. Low-level intervention provided 15 hours of support, medium provided 30 hours and high provided 40 hours of support. This intervention was to be delivered over a six-month period for each of the participant organisations to ensure consistency. In addition, access to other MHPP interventions was possible but due to the late stage of the programme it was not feasible for organisations to partake in an additional intervention other than the enhanced offer.

All the interventions undertaken started with data collection at the employer and employee level. This enabled an organisational level report to be provided to the employer. A bespoke action plan was created for each organisation. The action plan was based on the Stevenson and Farmer 'Thriving at Work Report' (2017). Within the Report, six Core Standards and four enhanced standards were identified to enable organisations to become mentally healthy workplaces. These were developed into a new national framework called the Mental Health at Work Commitment to have a clear roadmap employers could follow to achieve better mental health at work. This was led by The Mental Health at Work Leadership Council supported by Mind.

The resultant six Mental Health at Work Commitment standards, 21 sub-standards and 32 action indicators informed the final MHPP framework for the natural experiment:

Standard 1 – Prioritise mental health in the workplace by developing and delivering a systematic programme of activity.

Standard 2 – Proactively ensure work design and organisational culture drive positive mental health outcomes.

Standard 3 – Promote an open culture around mental health.

Standard 4 – Increase organisational confidence and capability.

Standard 5 – Provide mental health tools and support.

Standard 6 – Increase transparency and accountability through internal and external reporting.

To support the organisations to implement the Standards, thirty-two action indicators were developed with Mind and these formed part of the intervention work with the Engagement officers. In addition, a suite of support offerings was established including employee focus groups, wellbeing champions, line manager training sessions and coaching/mentoring for organisational Wellbeing Leads. The Action Plan developed at the outset of the intervention established the approach that would be undertaken within the organisation. It however, recognised the need to be flexible depending on changing issues or priorities within the organisation. The Action Plan enabled the organisation to work over six months of intervention focusing in the first 10 weeks on meeting Standard One which was perceived to be the building block of the intervention. Over the following 16 weeks, low, medium, or high support was provided to move organisations towards completion of Standards 2-6. To support engagement, organisations who completed all the action indicators within Standard 1 would be eligible for the West Midlands Combined Authority 'Thrive at Work' Foundation level accreditation.

In addition, based on earlier learning, questions focusing on the HSE workplace management standards were included in the employee survey. They cover six key areas of work design that, if not properly managed, are associated with poor health, lower productivity and increased accident and sickness absence rates. These are:

- **Demands** – this includes issues such as workload, work patterns and the work environment.
- **Control** – how much say the person has in the way they do their work.
- **Support** – this includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues.
- **Relationships** – this includes promoting positive working to avoid conflict and dealing with unacceptable behaviour. This was split into colleague and manager relationships to understand the difference.
- **Role** – whether people understand their role within the organisation and whether the organisation ensures that they do not have conflicting roles.
- **Change** – how organisational change (large or small) is managed and communicated in the organisation.

As part of the enhanced offer Affinity Health at Work provided the MHPP Status report which provided a summary of the organisations' status regarding the Mental Health at Work Commitment, work dimensions (i.e., design and management of work) and organisational and employee health and wellbeing. Reports were shared to each participating organisation at two timepoints: at the beginning and end of their engagement.

Summary of findings

Participation

41 organisations of varying sizes and sectors took part in the natural experiment. Most took part in the medium and high-level interventions and the characteristics of organisations that took part in these two levels of intervention were similar but differed in the low-level intervention. 37 of these organisations provided follow-up data, most that dropped out were in the high level of intervention. This was due to capacity within the organisation and creating the space for surveys and data collection work to be undertaken within the six-month window.

2,532 employees took part in the baseline survey and 1,956 at follow-up, characteristics were similar in the baseline and follow-up samples. Most employees were in organisations taking part in the medium

and high interventions, and the demographic characteristics of individuals in these levels of intervention were evenly spread, but they were different to those in the low-level intervention.

Of the employees, data from only 544 was paired at baseline and follow up. This was, in part, due to the unique identifier creation process where participants were asked questions to generate a unique 6 letter code. Unfortunately, the identifier creation process – although based on previously established research studies – was not completely understood by participants, resulting in unreliable data. Learning would suggest a different approach is used to pair participants in future studies and to utilise learning from large scale national studies such as Zoe.

Synthesis of MHPP status reports

The analysis of findings from the MHPP status reports provided to employers at the beginning and end of their engagement with the MHPP Enhanced Offer is illustrated in the Table 1 below in terms of the achievement of the Mental Health at Work standards. The Mental Health at Work Commitment is a simple framework that builds on what we know: based on the Thriving at Work standards, pulling from the pledges and standards that are already out there, using up-to-date feedback from UK employers and mental health experts. These standards provide a roadmap to achieving mental health outcomes for employees and employers.

Table 1: Standards achieved at baseline and follow-up	***Number of organisations achieving standards***	
Standard	**Baseline**	**Follow-up**
Standard 1: Prioritise mental health in the workplace by developing and delivering a systematic programme of activity	0	11
Standard 2: Proactively ensure work design and organisational culture drive positive mental health outcomes	2	15
Standard 3: Promote an open culture around mental health	1	8
Standard 4: Increase organisational confidence and capability	2	20
Standard 5: Provide mental health tools and support	28	36
Standard 6: Increase transparency and accountability through internal and external reporting	4	15

The analysis of the status reports also illustrated the changes to adapted HSE Management Standards over time. This is depicted in Table 2. The results were obtained through analysis of the employee level data captured at baseline and follow up.

Whilst the HSE Management Standards were not explicitly targeted as direct actions – except for the standard on open culture – overall, there is an improvement in all of the domains. This 'unintended' change is hugely powerful as these standards are at the heart of tackling the real causes of work related stress for people – by driving progress on these standards we are creating powerful foundations for people and organisations to thrive – and so it is really important to highlight What is significant is that there was an improvement in the positive experience by employees at follow up (T2) compared to baseline (T1) and reduction in negative experiences in between follow up (T2) and baseline (T1).

Table 2: Overall employee-level impact of interventions on the adapted 6 HSE Management Standards

Work area	Positive experience	Positive experience (T1)	Moderate experience	Moderate experience (T1)	Negative experience	Negative experience (T1)
Workload	**51%** +8%	*(43%)*	**33%**	*(38%)*	**16%** -3%	*(19%)*
Control	**64%** +8%	*(56%)*	**25%**	*(27%)*	**11%** -7%	*(18%)*
Work life balance	**64%** +6%	*(58%)*	**28%**	*(30%)*	**9%** -3%	*(12%)*
Role clarity	**81%** +3%	*(78%)*	**15%**	*(17%)*	**3%** -2%	*(5%)*
Open culture	**73%** +7%	*(66%)*	**19%**	*(23%)*	**8%** -3%	*(11%)*
Colleague support	**84%** +1%	*(83%)*	**9%**	*(9%)*	**7%** -1%	*(8%)*
Manager support	**82%** +6%	*(76%)*	**9%**	*(12%)*	**8%** -4%	*(12%)*

All organisations who took part in the enhanced offer demonstrated a position where all standards were improved during the intervention period, as shown in Table 2.

During the intervention period, one organisation, the highest scoring, achieved or partially achieved 100% of the identified actions at follow up. This achievement demonstrated that it is possible for organisations to make rapid progress when given clear support and implementation advice.

It should also be recognised that the even the lowest scoring organisation achieved or partially achieved 59% at follow up (this is an anomaly by roughly 20%). The programme sought to guide organisations on the journey and the fact that 59% was completed can be seen as a significant improvement.

Across the enhanced offer, organisations on average, achieved 89% of the 6 standards in follow up. It is also important to recognise that no organisations achieved fewer standards or actions in follow up. This is particularly important when implementing the workplace wellbeing agenda. The research team were cognisant that organisations may focus on what was being asked to deliver at each point of time and not remain too committed to work that had already been completed. This result means that organisations remained committed to the overarching strategic approach to implementing the action plans provided.

Overall, 57% of organisations achieved over 90% actions noted in the Mental Health at Work Commitment. This demonstrates that the standards are as relevant today as they were when published in the Thriving at Work Report (2017). It is recognised that the nature of work has changed significantly since the Covid -19 pandemic. Some organisations have developed and maintained hybrid working approaches which means that managers must navigate supporting employees in a different way. More broadly, economic inactivity in the UK had increased during the pandemic.

Office for National Statistics (ONS) figures showed that between August to October 2022 economically inactivity had increased by 565,000 people compared to pre-pandemic levels[13]. The action indicators developed by Mind and the MHAW Commitment also demonstrate a high degree of relevance. The action indicators provide the guidance and support to generate a holistic mental wellbeing approach across organisations from different sectors and organisational size as well as whether the workforce is in the workplace, working remotely or in a hybrid manner. In addition, this work demonstrates that organisations working on implementing the Standards therefore generate a movement which helps improve the HSE Management Standards, supporting organisations to create mentally healthy workplace which is felt by employees.

Change in Mental Wellbeing Scores

A small increase in mental wellbeing as measured by Short Warwick Edinburgh Mental Wellbeing Score (SWEMWBS) over time in each intervention level but these were not statistically significant. Modelling showed that, employees who received the middle intervention, had a significantly higher SWEMWBS score of 1.4 compared to those who received a low intervention. This difference reduced to 0.9 but remained significant after controlling for the demographic characteristics and clustering of the employees.

However, no such significant differences were found in the sensitivity analysis suggesting that individual variation, rather than intervention differences, was responsible for the changes seen.

Change in Depression Scores

Data, on depression, collected from the natural experiment showed a mean reduction in PHQ9 Scores. Over time in each of the intervention levels, but this was only meaningful and statistically significant in the low intervention (-1.3). Modelling showed PHQ9 was significantly lower, by 2.7 and by 2.1 among employees who received a medium and a high intervention level respectively, compared to those who received a low intervention. After controlling for the demographic characteristics and clustering of the employees there was only a significant 1.69 reduction in PHQ9 among employees who received middle intervention level compared with those who received a low intervention.

However, no such significant differences were found in the sensitivity analysis suggesting that individual variation, rather than intervention differences, were responsible for the changes seen.

Economic Analysis

MHPP has demonstrated a promising return on investment by saving costs associated with decreased absenteeism and presenteeism, which can offset the initial expenditure on implementing the programme.

The ROI (Return on investment) for the programme was determined using the following formula:

$$ROI = \frac{Cost\ of\ absenteeism\ and\ presenteeism_{\ Followup} - Cost\ of\ absenteeism\ and\ presenteeism_{Baseline}}{Total\ cost\ of\ the\ programme\ in\ the\ targeted\ organizations}$$

The Return on Investment (ROI) analysis incorporates costs related to the programme itself as well as costs incurred by organizations due to mental health sick leave and presenteeism. By considering all these costs, the programme has achieved a ratio of 1.29 for ROI, indicating it could serve as a cost-saving initiative from the employer's perspective i.e. for every pound (£) invested in employees' mental wellbeing, employers stand to gain £1.29 in benefits through reduced costs associated with mental health-related absences.

[13] Where have all the workers gone?: Economic Affairs Committee report - House of Lords Library (parliament.uk)

In comparison, it was noted in the Deloitte UK:

"*Mental health and employers – Refreshing the case for investment Report (2020)*[14] *"The results of our updated ROI analysis show a financial case in favour of employers investing in mental health. We now find that on average employers obtain a return of £5 for every £1 (5:2:1) invested, up from £4 for every £1 spent (4.0:1) in our previous report. However, there is a wide spread of returns from 0.4:1 all the way up to 11:1. Interventions that achieve higher returns tend to have the following characteristics:*

- *They offer a largescale culture change, or organisation wide initiatives supporting large numbers of employees.*
- *They are focused on prevention or designed to build employee resilience.*
- *They use technology or diagnostics to tailor support for those most at risk*" (2020 p5).

However, when widening the perspective from employers to society, and including not only the costs of the programme and associated costs due to absenteeism and presentism but also the EQ-5D-5L as a generic metric for capturing health-related quality of life (HRQOL), the results show that the packages did not produce significant changes in it over the study period. None of the programme intervention levels (high, medium, and low) are cost-effective when compared against each other. All estimated Incremental Cost-Effectiveness Ratios (ICERs) exceed the recommended willingness-to-pay (WTP) thresholds (£20K and £30K) in the UK, indicating the programme levels would not be cost-saving for each gained unit of HRQOL.

NICE's recommended willingness-to-pay thresholds (£20K-£30K) are specifically applied to cost-effectiveness analysis rather than cost-benefit analysis. The outcome of cost-effectiveness analysis yields the cost-per-gained-quality of life attributable to the program, distinguishing it from a cost-benefit analysis. Notably, there are distinctions between cost-effectiveness and cost-benefit analyses; while the latter quantifies both costs and benefits of a program in monetary terms, the former utilizes the monetary value for costs but quality-adjusted life years (QALYs) for benefits. Consequently, due to the absence of a monetized metric for cost-effectiveness analysis, these thresholds serve as recommended criteria for every health or health-related program/intervention in England. We acknowledge potential limitations in applying such thresholds; nevertheless, this methodology is employed in cost-effectiveness analysis to elucidate the value for money of an intervention in the UK.

Qualitative findings

The TDF themes identified below highlight the factors that either facilitate or hinder the implementation of workplace mental health interventions. We found strong commitment and understanding of the need for an inclusive strategy particularly in large organisations. There was recognition that such a strategy was insufficient without ongoing review to improve the balance of communication for employees to be engaged and empowered. Training and raising awareness around mental health was seen as a good thing. An unsupportive work environment where mental health stigma existed hindered workplace mental health interventions, whereas the need for a compassionate organisational culture was recognised. However more drivers exist to ensure policies and procedures are right, than to change culture which potentially the more important factor.

- **Theme 1**: Current Wellbeing Strategy Implementation, mapped onto the knowledge domain of the TDF. It highlighted the contrast between advanced organisations such as NHS Trusts and other larger public organisations, compared to smaller, less-established entities, emphasising the challenge of implementing strategies effectively. Concerns about integrating mental health into

[14] deloitte-uk-mental-health-and-employers (1).pdf

health and safety highlighted the need for specialised training and the potential risks associated with handling mental health issues without proper expertise. Obstacles related to staff engagement and communication challenges, included issues with information accessibility and promotion of wellbeing initiatives. Employees had doubts about survey completion leading to tangible actions which appears to be compounding the issue of successful implementation.

- **Theme 2**: Strategy Review and Evaluation, mapped onto the skills domain of the TDF and highlighted that an effective strategy review and communication are integral components of fostering a healthy and supportive work environment. The insights from sub-themes signal for a concerted effort to formalise an evaluation process and improve communication strategies, thereby enhancing the overall wellbeing of employees in the dynamic landscape of the workplace.
- **Theme 3**: Formalisation and Inclusivity mapped onto the TDF domain of Social/Professional Role and Identity. It highlighted the systematic development and implementation of well-defined procedures, protocols, and initiatives aimed at creating an inclusive workplace. This theme emphasises the organisational commitment to fostering an inclusive environment through structured policies and practices, recognising the diverse needs of the workforce and addressing them formally and systematically to enhance overall wellbeing.
- **Theme 4**: Interventions, mapped onto the TDF for Beliefs about Capabilities. It highlighted some of the concerns in relation to mental health interventions in the workplace and the inherent requirement for confidence, self -belief and a supportive workplace culture for staff to feel empowered to be able to intervene and support colleagues.
- **Theme 5**: Feedback and Efficiency Assessment, mapped onto the TDF of Optimism. This theme has underscored the importance of a strategic approach to staff surveys, balancing frequency and relevance, and addressing survey fatigue to maximise their positive impact on employee wellbeing. Effective communication of survey results and subsequent actions is crucial for maintaining employee engagement and demonstrating the organisation's commitment to addressing wellbeing concerns.
- **Theme 6**: Organisational Culture, mapped to TDF of Beliefs about consequences. Employees' experiences highlight the positive impact when leaders prioritise and actively commit to fostering a supportive environment for mental health. Conversely, the absence of such commitment is noted as a potential challenge, influencing the overall culture within the organisation. The importance of leadership commitment in cultivating a culture that values and prioritises employee wellbeing and challenges the negative discourse and stigma is evident. The narratives in this theme have emphasised the need for continuous efforts to embed this commitment at all levels.
- **Theme 7**: Whose responsibility? Mapped to the TDF of Reinforcement. This theme emphasises the debate around who is responsible for looking after mental health in the workplace and suggest should there be more government buy-in. Parallels between physical and mental health have been highlighted which emphasises that while employers can provide support and adjustments the ultimate responsibility lies with the individual. It is important to recognise that employers have a duty to protect staff from stress in the workplace. Creating a psychologically safe workplace does not appear to be a driver for employers as there are very limited sanctions though the Health and Safety Executive.
- **Theme 8**: Moving Forwards, mapped to the TDF of Intentions. This theme has highlighted the need to continuously move forward but to do that needs a pro-active and enthusiastic team driving the agenda.

- **Theme 9**: Sustainability, mapped to the TDF of Goals. This theme highlighted that ensuring that the strategies and interventions put in place for employee wellbeing are not only effective in the short term but are sustainable and can withstand the test of time. The narrative delves into how the organisation plans to embed a culture of wellbeing into its core values, policies, and practices to ensure continued support for employees' mental health.
- **Theme 10**: Challenges. Mapped to the TDF of Memory, Attention and Decision Processes. It highlighted the importance of fostering an open and compassionate space where employees can express their emotions and seek support, reinforcing the significance of acknowledging and addressing this facet of wellbeing within the workforce.
- **Theme 11**: Ethos, mapped to the TDF of Environmental Context and Resources. This theme reinforces how individual employees perceive and incorporate their own values into the organisational culture and ethos. The narratives have also identified some of the barriers to embedding a positive wellbeing within organisations.
- T**heme 12**: Resonances, mapped to the TDF of Emotion. The narratives reveal the interconnectedness of emotions and wellbeing, illustrating how specific events or circumstances can resonate emotionally and shape the overall psychological landscape of individuals within an organisation. Understanding these emotional resonances is crucial for comprehending the intricate layers of wellbeing and devising effective strategies to support mental health.
- **Theme 13**: Keeping Going, mapped to the TDF of Behavioural Regulation. It highlighted the challenges of keeping wellbeing initiatives moving forwards and ensuring the integration of wellbeing initiatives into the daily operations and culture of the workplace.
- **Theme 14**: Hope, mapped to the TDF of Optimism demonstrating the commitment and on-going hope and determination to take forward the mental health and wellbeing agenda.

Consistency with other literature

There have been several systematic reviews in recent years investigating the efficacy of workplace interventions. These report that most studies result in improvements in psychological wellbeing (Ryan et al, 2021, Anger et al, 2024). However, we did not find this in our natural experiment study, within the short time span of delivery. We cannot be so certain of our results as our study design, natural experiment, was limited (as described below). Many others have been randomised controlled trials with the ability to determine causality (Anger et al, 2024). In addition, most studies to date have focused on individual level, rather than organisational level interventions (Yarker et al, 2022; Anger et al, 2024) and this may account for a stronger effect size.

Few studies to date have calculated return on investment, but four out of six studies reviewed have found a reduction in workplace absences (Anger et al, 2024), a finding consistent with our own, at the six-month point.

Systematic reviews have also explored factors associated with successful implementation of workplace wellbeing initiatives and found little evidence is available. Ryan et al (2021) found no discernible patterns between the types or numbers of behaviour change techniques employed and intervention effectiveness. However, it has been noted that tangible changes preceded improvements in health and wellbeing, indicating intervention success cannot be attributed to non-specific factors. Yet some interventions had beneficial effects through mechanisms not planned as part of the intervention.

Three factors associated with successful implementation were continuation, learning, and effective governance (Daniels et al, 2021). These were consistent with some of our findings, continuation mapped to themes 8, 9 and 13, learning to themes 1 and 3 and effective governance to themes 1, 2 and 5. However in contrast our findings highlighted the strong need for culture change being felt at ground level. This is perhaps more in keeping with the findings of Yarker et al (2022) which found facilitators of

workplace mental health wellbeing included positive disclosure by line managers, completion of interventions in work time, scheduling flexibility and trainer credibility. Barriers included managers not prioritising interventions, lack of suitable training of facilitators, competing priorities, workload issues and staff shortages. However, the studies reported in this review were deemed to be low quality.

Strengths & limitations of the natural experiment research

Our natural experiment was a large-scale study and although not a randomised controlled trial, there were similar characteristics between participants across varying intervention levels, and any differences were fully adjusted for. Although not all responses were paired, over 500 were linked, and characteristics of employees at baseline and follow-up were similar in the non-paired samples.

We cannot be certain of our health outcome (HRQOL) results for several reasons, firstly, the lack of a control group with organisations not taking part in any MHPP intervention. We had planned for a control group but due to the short time limit for the trial we were unable to operate a wait list control and no organisations volunteered to act as a control.

We do not know for example, if over the same period, without any level of MHPP intervention, that mental wellbeing outcomes would not have deteriorated. Neither do we know, without the MHPP intervention, whether mental health outcomes might have improved. Yet we can be reassured that no significant change shows mental health did not worsen during the MHPP intervention. We have seen from the evidence within the Affinity research and the Mental Health at Work research with Warwick University there may be some promising early shoots of positive change of organisational level outcomes.

Secondly, as a natural experiment, without randomisation into the differing levels of intervention, we cannot be sure that all confounding factors, and in particular residual confounding, was controlled for. This means that an unmeasured factor, unknown to us, may have been at play influencing the results.

Thirdly the short length of time, six months, before follow-up is questionable that the intervention had time to take effect and any difference would be seen. An organisational strategy is likely to need significant time to bed in and its impact to be felt by employees. This was echoed in the qualitative responses where both employers and engagement officers identified the time to embed the Action Plan and start delivery of the intervention could vary from one month to 4 months within different organisations.

Regarding the economic analysis particularly, the reduced number of observations for certain interventions over the study period, despite the use of imputation techniques, mean that the produced and simulated quantities particularly for HRQOL might not have been a true reflection of the actual results. The imputation techniques are predicting and simulating the missing values based on a limited set of other factors such as age, gender, mental health situation, however, it is always restricted in the numbers of the factors which can be used for such imputations.

Additionally, the HRQOL in this project has been captured by EQ-5D-5L, which is the most common generic metric for measuring quality of life in England. However, the optimality of EQ-5D in measuring mental health interventions and capturing quality of life is unclear.

Regarding the qualitative analysis, using the TDF has its limitations; it does not allow for findings to emerge beyond the framework in the way that open coding does, and so insights may have been missed. Although in other areas of MHPP, further qualitative analysis using open coding were conducted and can be read as supplementary material. This analysis provides a fuller immersion into the data and reveals additional patterns within and across cases and themes in the data. To inform further refinement, make sense of and identify, describe, and interpret additional emergent codes other existing frameworks and theories were reflected upon, such as the Implementation Outcome Framework (Peters et al., 2013) and the updated Consolidated Framework for Implementation Research (Damschroder et al., 2022). This

approach proved useful in being able to combine the advantage of the TDF of capturing potentially modifiable determinants of individual-level cognitive constructs thought to influence behaviours and offering a basis to link these determinants more strongly to analytical levels beyond individual level to organisational level constructs. A further insight report building on the initial review of the TDF has been conducted and is available for separate review[15]

Lastly, with 33 of our approached organisations declining to participate – and without data on the representativeness of employees taking part in the survey - we cannot be confident that our findings are generalisable.

These 33 organisations cited several reasons for declining to participate in the natural experiment. These included survey fatigue; other surveys ongoing at the same time; lack of buy in from senior management and the time commitment involved. However, all these organisations were given the opportunity to receive support directly from MHAW and TAW teams – but without the added rigour and resource needed by the Enhanced Offer.

Implications for further research, policy, and practice

Well-designed studies, such as randomised controlled trials, are needed to fully test the effectiveness of programmes such as MHPP, and these need to be followed-up over a sufficiently long period of time to allow for organisational change to become embedded. From learning from surveys such as Britain's Healthiest Workforce[16] a longitudinal data set would create the longitudinal level to provide a robust data set to enable effective measurement of change in health outcomes. There is limited organisational level intervention research to describe how long is necessary to be optimal but research which includes a study by Chen et al, suggested 5 years provided sufficient data to show sufficient change in individual level health outcomes.[17]

There is not currently sufficient evidence to recommend the Enhanced Offer should be rolled out more widely with a single goal of improving the mental wellbeing of employees. However, it may be prudent to conduct longer follow-up before concluding it is not associated with any improvement. Also, MHPP may achieve a return on investment through a reduction in mental-health related absenteeism, without causing any harm in the short term. However, results suggest important changes are happening at an organisational level to indicate the importance to continue to track this organisational change over time – to assess how these strides in key intermediate outcomes over time reach employees more longitudinally- therefore we recommend using this framework to continue to evaluate and study over longer time frame and fund more longitudinal work in this space.

Creating a supportive culture around mental health in the workplace that is felt at ground level may be the key to successfully implementing effective workplace mental health initiatives. The potential greater benefit of individual level initiatives in the workplace in comparison to organisational level changes needs to be explored.

[15] MHPP Enhanced Offer Qualitative Data Analysis Report.docx (sharepoint.com)

[16] Britain's Healthiest Workplace | Vitality

[17] Chen, T.H.; Huang, J.J.; Chang, F.C.; Chang, Y.T.; Chuang, H.Y. Effect of workplace counselling interventions launched by workplace health promotion and tobacco control centers in Taiwan: An evaluation based on the Thrive at Work charter. PLoS ONE 2016, 11, 1–11. [https://doi.org/10.1371/journal.pone.0150710]

Conclusions from the Natural Experiment

In conclusion, the MHPP exhibits cost-saving potential from an employer's perspective by mitigating costs associated with absenteeism and presenteeism. However, benefits to employees, specifically their health-related quality of life, mental wellbeing and depression scores showed no change across the 6-month intervention period, where there were significant improvements, these were not robust to sensitivity analysis, either when comparing differences over time or level of intervention, at least in the short term.

Qualitative analysis helps us to understand why this may be. It highlighted that despite good intentions, policy and strategy changes at organisational level were not necessarily communicated in a way to engage and empower individuals, nor did they necessarily produce a culture that felt psychologically safe in such a short space of time. This was consistent with the work undertaken in the MHAW research which echoed the challenge of requiring sufficient time to implement the standard. However, we did demonstrate significant progress being made in changes to employers' policy and practice which we believe will lead to improved outcomes.

However, the evidence from the movement in the Standards and the 7 adapted HSE Management Standards is demonstrating a promising position. Whilst the impact on mental health outcomes cannot be proven during a 6-month intervention, there has been a positive movement in each of the domains. As identified in the newly created MHAW Theory of Change (Figure 6) the implementation of the employer and employee interventions should lead to improved outcomes including literacy, cultural change, policy and practice change and stigma reduction. These wider determinants of poor mental health within the workplace, if not addressed, lead to poor mental health outcomes.

The work undertaken during the natural experiment has demonstrated that with support from the engagement officer has enabled organisations to go further faster. The findings from the MHAW reviews suggest that it takes 18 months to 2 years to successfully implement. The focused work with the organisations within the research has shown similar levels of results in 6 months.

5.3 Pilots testing novel interventions

Following an initial literature review and research to explore the wellbeing landscape across Midland's employers, the research team designed a set of novel interventions to tackle a selection of workplace challenges. It came at a time when there was a national drive to reduce the number of people exiting the workplace due to poor health and or disability; reduce the increasing levels of economic inactivity, particularly helping those with poor mental or physical health to get back into work. At a national level several interventions such as Individual Placement and Support (IPS), Access to work, and Employment Support were being rolled out and it was identified that more could be done in the workplace to test interventions that may support this ambition.

Several interventions were developed, which are briefly described below. Full reports are also available separately for each of the interventions in Appendix A (Documents F to N).

Organisations were able to participate in the novel interventions alongside either MHAW or TAW or both. This was more pertinent during MHPP 1.0. During MHPP2.0 - due to the timings of the interventions – organisations undertaking the Enhanced Offer had limited engagement with these novel interventions.

5.3.1 Line Manager support and joint employee/employer interventions

5.3.1.1 MENTOR

MENTOR was developed to support 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. The intervention involved remote delivery of 10 individual and joint sessions with employees and their managers, delivered by a Mental Health Employment Liaison Worker (MHELW). This study was a randomised controlled trial, with participants allocated to either a waitlist control group or the intervention.

Summary of key findings

The pilot found that the feasibility and acceptability of MENTOR was satisfactory, and preliminary evidence indicates that MENTOR may improve employee's mental health, productivity, and the mental health knowledge of managers. The co-design and interdisciplinary approach were highlighted as major strengths of the study, suggesting potential for future research and application.

Impact

Twenty-four employee-manager pairs started the intervention and 50% of these pairs were retained and reached at least seven sessions. This was the first study to assess the acceptability and feasibility of a joint and early intervention for employees with a diagnosed mental health problem and their managers at work. The preliminary evidence was promising and was used to inform further research.

Suggested Adaptations

Improvements to the format of MENTOR were required to increase retention rates. Specifically, fewer sessions due to logistical challenges delivering ten sessions. Reduced manager involvement due to workload demands and capacity was also suggested. Overall, a larger study is needed to test the effectiveness for improving individual and organisational outcomes.

5.3.1.2 Employment Liaison Worker Pilot (ELWP)

Taking learnings from the delivery of MENTOR, adaptations were made to the intervention, and it was retitled as the Employment Liaison Worker Pilot (ELWP) and a more flexible and inclusive model was delivered concurrently with MENTOR. Delivery ran from December 2021 to May 2022, led by the MHPP team at Mind in collaboration with local Minds. The aim was to understand whether adaptations enhanced participation and helped to achieve intended outcomes.

Summary of key findings

Mind conducted a non-academic analysis of ELWP data. A shortened Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS), the Rosenberg Self-Esteem Scale (RSES), and Social Provisions Scale (SPS) found evidence to suggest the intervention had a positive impact on psychological wellbeing, self-esteem, and social connection for participants. Participants with lower levels of wellbeing experienced some of the strongest improvements. All versions of the service led to improvements in wellbeing. There were improvements in half of all measures of productivity. All clients rated the service highly and would recommend the service to others experiencing problems with their mental health or wellbeing. Analysis showed a shorter service could still have a meaningful impact on wellbeing. With limited data, no conclusions could be drawn regarding the impact of manager involvement. The service received an average rating of 9.41 out of 10.

Summary of key adaptations

Key adaptations included removing the need for participants to have a mental health diagnosis to take part, offering participants several versions of the intervention, reducing the number of sessions they had, and adapting the recruitment mechanisms and no longer making manager involvement compulsory.

Impact

27 clients completed sessions, the key data set used by Mind for understanding the service's impact on wellbeing and productivity referred to the 16 clients who completed the pre- and post-service wellbeing measures. 14 out of 16 SWEMWBS scores improved, 9 of these by more than 3 points; these are considered meaningful changes. 12 out of 15 RSES scores improved. 11 out of 14 SPS-10 scores improved. The impact was greater for those who reported lower pre-service scores across each measure. This suggests the service is most effective in assisting people experiencing low levels of wellbeing. The data suggested the service could have a positive impact on clients' perception toward their work, organisation, and productivity, particularly their sense of usefulness. All clients would recommend the service to a colleague, friend or family member.

Further Research

Gather further evidence, building on learnings from MENTOR and the ELWP to understand the differences in impact on wellbeing of a rigid service model vs one that is more flexible. Investigate the effects of a shorter service that includes manager involvement whilst maintaining the breadth of the audience. Gain more evidence that explores the extent to which wellbeing improves for people without a mental health diagnosis.

5.3.1.3 MENTOR 2.0

Learnings from the delivery and evaluation of MENTOR and the ELWP, informed the development of MENTOR 2.0. Previous participants formed focus groups and were consulted on our proposed adaptations. They also offered new insights to help refine our delivery approach. The intervention was shortened from ten to five sessions and with manager involvement being reduced to one joint employee-manager session just beyond the mid-intervention point. MENTOR 2.0 retained the accessibility criteria of the ELWP with a diagnosed mental health problem no longer needed to take part.

Summary of key findings

First, quantitative analysis showed that psychological distress significantly decreased, whilst productivity, work engagement, psychological flexibility, and interpersonal relationships all significantly increased from baseline to post-intervention. Second, the results showed that as 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.

Impact

MENTOR was delivered to 21 employee participants using an interval contingent study design. 16 managers participated, 4 of which managed for 2 separate employee participants. Retention rates improved to 100% with all participants completing the full intervention. Few sessions were cancelled/rearranged (5.6% n=105), these were due to limited work capacity or illness. On average, it took 65 days for participants to complete sessions 1-5. 91% of sessions lasted the intended 50+ minutes.

Qualitative feedback from participants reveals the positive impact MENTOR has had on their mental health and work life.

Discussion

This pilot study assessed the preliminary effectiveness of the adapted MENTOR 2.0 intervention for employees, including those with and without mental health conditions. The findings provided evidence of improved psychological health outcomes over the course of the intervention.

Quantitatively, we observed a significant reduction in psychological distress, as evidenced by the decrease in GHQ-12 scores from baseline to post-intervention. This reduction suggests that the intervention effectively alleviated notable distress among participants. Concurrently, there were significant increases in productivity, work engagement, psychological flexibility, and interpersonal relationships at work. These improvements suggest that MENTOR 2.0 positively impacts various aspects of workplace functioning and psychological wellbeing.

Regarding psychological processes, the study found that as stress levels decreased, there was an increase in work engagement, interpersonal relationships, and psychological flexibility. Similarly, positive mood correlated with increased psychological flexibility. An interesting finding was that baseline levels of psychological distress moderated several relationships, such as between stress and mental health awareness, and positive affect and interpersonal relationships. In contrast, having a diagnosed mental health condition did not moderate these outcomes, suggesting that the intervention's effectiveness was consistent regardless of mental health status.

Interestingly, while managers reported a significant improvement in their relationships with employees, this change was not mirrored in the employee-reported outcomes. This discrepancy might be attributed to employees' pre-existing positive perceptions of their managerial relationships, as indicated in the qualitative feedback. This change may stem from the revised intervention's structure, which now includes only one joint session with the manager. Reduced managerial involvement from the previous MENTOR 1.0 version might have altered employee and manager perceptions. While additional joint sessions might benefit some employees, balancing these with the managers' time commitment to the intervention needs to be considered.

The results of this study resonate with the growing body of research emphasising the importance of workplace interventions in improving mental health and overall wellbeing (Goodwin et al., 2013; Sairam & Voruganti, 2022). The significant reduction in psychological distress and improvements in psychological flexibility and interpersonal relationships observed in our study align with findings from Kinman and Clements (2021) and LaMontagne et al. (2014), who highlighted the important role of supportive workplace environments in mitigating mental health issues among employees. Our findings also extend the understanding of the role of manager-employee relationships in workplace mental health, underscoring the importance of managerial support as emphasised by Weinberg et al. (2018) and LaMontagne et al. (2007).

Furthermore, the observed improvements in psychological health outcomes parallel the objectives of the NHS Talking Therapies programme and IPS, reinforcing the potential of employer-based interventions like MENTOR 2.0 in addressing common mental health disorders. However, the disparity in the perceived improvement of employee-manager relationships between managers and employees highlights the complex nature of these relationships and the need for nuanced approaches, as suggested by Dimoff & Kelloway (2013) and Duffy (2009). This study's findings contribute to the existing literature by providing empirical support for the effectiveness of multifaceted interventions like MENTOR 2.0, particularly in settings where access to comprehensive mental health services is limited.

Furthermore, MENTOR has 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.

Further Research

Further research using a larger sample, longer term follow ups and comparison control group would be useful to determine the generalisability of MENTOR to the wider population. Both employees and managers said that having a follow up session would be beneficial, so we can consider adding this to the model.

Links to more information

Prudenzi, A., Gill, K., MacArthur, M., Hastings, O., Moukhtarian, T., Jadhakhan, F., ... & Marwaha, S. (2024). Supporting employers and their employees with Mental hEalth conditions to remain eNgaged and producTive at wORk (MENTOR): A feasibility randomised controlled trial. Journal of Contextual Behavioral Science, 100720. https://doi.org/10.1016/j.jcbs.2023.100720

Prudenzi A, Jadhakhan F, Gill K, MacArthur M, Patel K, Moukhtarian T, et al. (2023) Supporting employers and their employees with Mental hEalth problems to remain eNgaged and producTive at wORk (MENTOR): A feasibility randomised controlled trial protocol. PLoS ONE 18(4): e0283598. https://doi.org/10.1371/journal.pone.0283598

5.3.1.4 PROWORK - Return to work intervention

Line managers have a critical role in both the mental health and productivity of their direct reports. However, workplace mental health interventions targeted at line managers to date have largely focussed on increasing their awareness of mental health conditions.

Researchers piloted return-to-work intervention toolkits called PROWORK in a randomised cluster trial with participating organisations randomised to intervention (n=5) or control (n=4). Employees on long-term sick leave (≥15 days) and their managers were recruited to participate. Mixed methods were used to collect data on recruitment, drop-out, adherence, acceptability and feasibility.

Primary research outcome of interest was total sick leave days until first day back at work (partial or full return). Secondary measures included self-reported mental health, return-to work support, communication.

Summary of key findings

Participation was low (employees n=19 intervention; n=23 control; managers n=18 intervention; n=21 control) and there was insufficient data to assess difference in the sick days between the intervention and control group. However, PROWORK reduced symptoms of anxiety and depression in the intervention group over time. Qualitative analyses show that PROWORK was acceptable, of high quality, easy to use and beneficial. HR (Human Resources) and senior management saw the value of PROWORK and are willing to adjust their policies and procedures to embed PROWORK.

Summary of key adaptations

Throughout PROWORK key adaptations were made to recruitment and engagement activities including webinars, posters, newsletters, use of workplace champions, stakeholder engagement, posting out study information to employee home address instead of emailing. Information on COVID-19 was removed from the toolkits in 2023.

Total impact

The PROWORK return-to-work intervention can make a difference to employee wellbeing and manager confidence in managing employees on sick leave.

5.3.1.5 PROWORK toolkit – natural embedding

Eight new organisations were recruited and provided with the PROWORK toolkits to embed into their existing policies and practices. Mixed-methods data were collected pre and post embedding.

Summary of key findings

It took an average of 9 months for organisations to embed parts or whole of the toolkit within their existing policies and processes.

Total impact

Organisations saw the value of PROWORK toolkits for their organisations and were willing to embed these.

5.3.1.6 PROWORK - Absence Management Framework

This intervention explored whether employers in PROWORK could meet the current criteria in a best practice Absence Management Framework developed by Affinity Health at Work.

Summary of key findings and total impact

Most PROWORK organisations did not meet the full evidence for best practice in the Absence Management Framework. Therefore, PROWORK toolkit brings added benefits to organisation's existing policies and practices.

Topics for further research

For a main trial for PROWORK, at least five years of funding is needed to allow embedding of toolkit into existing processes and practices. More organisations are also needed to take part. This should therefore be a pragmatic main trial where organisations embed the toolkit first, then data is collected on its impact over a longer term, to allow for a sufficient number of participants per organisation.

5.3.1.7 Managing Minds

In the first phase of funding, the Managing Minds at Work (MMW) digital learning package was co-designed using the latest evidence to provide line managers with the knowledge, confidence, and management competencies to prevent poor mental wellbeing at work. In the second phase of funding, we adapted the intervention to provide an enriched virtual model of blended learning called Managing Minds at Work Plus (MMW+).

Summary of key findings

A feasibility cluster randomised controlled trial of the MMW digital learning for line managers showed good recruitment and retention rates. At 6-month follow-up, line managers in the intervention arm had significantly improved outcomes relating to: confidence to create a mentally healthy workplace; mental health literacy; management competencies in preventing stress; psychological wellbeing. There were significant differences between intervention and control arm for all outcomes at the 3-month follow-up. The Managing Minds at Work Plus (MMW+) was feasible and acceptable to participants and engagement was good. The addition of facilitated group sessions alongside the MMW digital learning provided an opportunity for groups of line managers to discuss and reflect on the topics covered and MMW and to develop specific action plans to tackle issues relevant to their context. Further data needs to be collected from direct reports over a longer period to assess any changes in their mental health and productivity.

Summary of key adaptations

Following feedback from MMW, MMW+ was developed to further support line management engagement and behaviour change. The key adaptation was the addition of four groups sessions to run alongside the MMW digital learning: a launch/kick-off event, two facilitated workshops to discuss

specific content areas, a follow-up/close event. The MMW+ intervention was tested in two organisations, one engaging in face-to-face group sessions and the other conducting these sessions online due to the geographical dispersion of their line managers.

Impact

Line managers completing MMW show improvements in their knowledge, confidence, and management competencies in preventing and managing mental health in the workplace as well as improvements in their own psychological wellbeing. The facilitated group sessions in MMW+ allowed line managers to discuss their learning in relation to their specific context and start to develop action plans to put the learning into practice.

Link to more info

Research Protocol for MMW: https://www.researchprotocols.org/2023/1/e48758

MMW Intervention development and description: https://www.mdpi.com/1660-4601/19/13/8006

5.3.1.8 Mental Health First Aid

Mental health literacy is knowledge and beliefs about mental disorders which can aid their recognition, management or prevention. Increased mental health literacy has been associated with increased help seeking behaviours in individuals with mental health problems. Mental Health First Aid (MHFA) is one of several training programmes designed to improve mental health literacy. Over six million people have been trained in MHFA worldwide and the program is active in 30 countries. Despite its popularity and widespread adoption, relatively little research has been conducted to evaluate MHFA's effectiveness in relation to outcomes for people who complete the training and become Mental Health First Aiders, particularly in workplace settings. Even less research has examined the outcomes for the beneficiaries who receive the "first aid" from those trainees. We conducted a rapid review of the evidence on MHFA in the general populations and the workplace to provide an up-to-date summary.

Summary of key findings

There is relatively consistent evidence that MHFA training is effective in increasing knowledge and confidence of people who receive the training. However, there is currently insufficient evidence to suggest that those changes translate into increased helping behaviours from those trained in MHFA. Furthermore, there is in no evidence that MHFA training improves outcomes relating to people who might seek help in the communities where training has taken place, whether that be workplaces, schools or other settings. There are well-documented barriers[18] to MHFA being implemented effectively and resourced sufficiently post-training, and this may in part account for some of the lack of effectiveness demonstrated by the evidence to date.

Impact

MHFA is an effective mental health literacy training intervention and has been shown to increase the mental health knowledge of people who complete the training. However, there is currently no robust evidence of impact on the benefits to people who receive an intervention from the MHFA trained individual.

Topics for further research

- To assess any impact that MHFA training has on the mental health outcomes of people that MHF Aiders (trainees) assist in the intervention.

[18] Narayanasamy et al. (2021). Investigating the barriers and facilitators to implementing mental health first aid in the workplace: a qualitative study.

- To explore strategies that MHF aiders can use post an intervention to look after their own wellbeing.
- To identify approaches which can support MHF aiders in the longer term for example, reflective learning sets and provide learning for organisations from interventions undertaken.
- To explore how MHFA can be integrated into a wider HWB programme which addresses prevention as the golden thread rather than a crisis intervention model.

5.3.1.9 This is Me

Context

This is Me is mental health initiative set up as part of the Lord Mayor's Appeal in greater London. It was established to provide employers with tools to support change attitudes towards mental health and stigma in the workplace. It does this through:

- Storytelling campaign, which enables staff at all levels within organisations to share their story of their individual experience of mental health.
- Green Ribbon wearing campaign, worn in workplaces for mental health events and more broadly to demonstrate a commitment to reducing mental health stigma.

An academic review was undertaken of This is Me by analysing data sent out annual surveys between 2017 and 2022 and provided the MHPP research team with surveys from 2019 onwards to evaluate. The research team also conducted a follow-up survey and interviews with participating organisations in both campaigns.

Summary of key findings

- The highest survey completion rates were received for the 2019 (n= 235) and 2020 (n=319) surveys with significantly lower survey engagement in 2021 (n=168) and 2022 (n=84). For the survey carried out by the research team, only 43 organisations took part. A quarter of organisations completed at least two annual surveys with most organisations only completing one.
- Organisations found the campaigns useful, especially during COVID-19 pandemic when poor mental health was more prevalent than usual.
- Most felt the campaigns helped improve manager awareness, changing attitudes and stigma around mental health.
- In 2019 and 2020, most organisations reported there was support and engagement in the two campaigns within their organisation including senior management. By 2021 and 2022, the engagement had dropped with around a third reporting that there was lack of time and resources with engaging with the campaigns.
- In terms of evaluation, across all the survey years, most organisations did not measure the impact of the campaigns on mental health, whilst others indirectly measured the impact though absence data, and annual surveys with a question(s) on mental health. Other measures were softer including relying on feedback from HR and champions or focusing on engagement data with stories or green ribbon campaign. Only one organisation (2019 survey) reported established KPIs on mental health which were measured quarterly. However, it was not clear if they measured and analysed the impact of the campaign on mental health.
- In the 2021 and 2022 surveys, some organisations stated they needed help with how to measure impact of the campaigns.
- From interviews conducted by the research team, a key theme was around 'big bang and fizzle'. Following a big launch event for the campaigns at the start of engagement, participants felt the on-going guidance for next steps from This is Me fizzled out. Participants were unsure where to go next with the campaigns or with improving mental health in their workplaces.

Summary of key adaptations

- Questionnaires were amended to improve data collection and renamed the surveys to encourage participation.
- Over the COVID year adaptations were made to the initiatives to run remotely/online

Total impact

Overall, there is positive engagement with the two campaigns from employees within the participating organisations. The campaign also made a positive difference to attitudes and stigma of mental health in workplaces. However, the direct impact of the campaign on mental health is not measured by many organisations and more support is needed by some organisations in keeping the topic of good mental health going.

Topics for further research

More research is needed around the actual impact of specific mental health campaigns on mental health itself. With so many different initiatives in workplaces, most found it difficult to assess direct impacts.

Link to more info

https://www.thelordmayorsappeal.org/initiatives/a-healthy-city/#section-2

Recommendations

More collaboration is needed between charities running mental health campaigns and universities to support the measurement and analyses of impact. The data received from This is Me was in an excel format and not se-up for deep analyses or easy transfer to a statistic software package.

Conclusions from the line manager support and joint employee / employer interventions

Overall, the line manager and joint employee interventions provided an opportunity to test new models of work. PROWORK and Managing Minds have developed excellent tools to support line managers who have greater levels of awareness and confidence when dealing with mental health problems at work. This approach, whilst still early, is showing promising results. It is argued that as line mangers play such a critical role in the creation and maintenance of culture in an organisation, they should all have mandatory training as part of their continuous professional development.

MENTOR has been adapted to provide support to both the employees and line managers. This creates an opportunity to navigate what can be, at times, very difficult discussions. In addition, the model has developed a new workforce approach using lived experience and expertise within a rounded workplace setting, i.e., the Employment Liaison Worker. This approach has helped to reduce the demand by not using staff from the existing NHS workforce. Workers have been recruited from the VCSO setting thus also enables a slightly lower banding.

Each of these interventions will be subject to ongoing research and further testing.

5.3.2 Employee-level novel interventions

In addition to the line manager research programmes, it was identified that there was a significant cohort of individuals in the workplace who are experiencing poor mental wellbeing. It was evident that a significant number of individuals within the workplace may be in a position where proactive or promotional interventions may assist whether they had failed to seek help or were below clinical thresholds for support. Symptoms may have been poor mood regulation, disordered eating or poor sleep. All these symptoms were identified as indicators of the wider determinants that can contribute to poor productivity in the workplace.

Whilst employers are not required to provide health intervention per se, they do have a role in ensuring that work does not contribute to poor health outcomes. It is evidenced that organisations who have implemented Employee Assistance Programmes have an average usage by employees of 12%[19]. It therefore could be argued that more could be done to support workers take preventative and promotional wellbeing approaches.

One in six workers experience mental health problems. Poor mental health is associated with increased rates of absenteeism, presenteeism and reduced productivity, costing the UK economy £56 billion in 2020-2021. The workplace offers a sustainable setting for providing mental wellbeing support at scale, whilst overcoming the many barriers to accessing timely treatment through traditional healthcare pathways. Furthermore, there is a proposed average return on investment of £5 for every £1 spent on workplace based mental health interventions[20].

Researchers identified several opportunities to test novel approaches in the workplace setting thereby attempting to support employees with therapeutic interventions as outlined below:

5.3.2.1 REST

Researchers at the University of Warwick developed REST, which is an 8-week online, self-guided cognitive behavioural therapy (CBT) based programme for stress, depression, and anxiety. It incorporates therapeutic techniques such as thought and emotion monitoring, behavioural activation, cognitive restructuring, and goal setting and is designed to be delivered through the workplace. The acceptability, feasibility, and preliminary efficacy of REST for employees in the workplace was evaluated through a mixed method randomised controlled trial. This involved 25 participants being exposed to the REST intervention and 27 participants joining a waitlist control group that accessed the intervention later. All participants completed an online questionnaire prior to starting the intervention, immediately after completion of the intervention (at 8 weeks) and subsequently at 3, 6 and 12 months. This included questions regarding their mental health and wellbeing, quality of life and work productivity. Ten participants also took part in an interview about their experiences of completing the REST intervention.

Summary of key findings

A total of 33 organisations agreed to facilitate the delivery of REST and the trial through their workplace. From these organisations and businesses, 52 employees agreed to participate in the trial. Adherence/ usage of the REST platform was 50% and high acceptability and satisfaction was reported by participants within the interviews. In terms of efficacy, there was a reduction in depression and anxiety symptoms post-intervention and at follow-up timepoints across all participants and over time. However, there were no statistically significant differences between the intervention and control group.

Key conclusions and impact

These results provide preliminary support for the implementation of the REST intervention through the workplace. However, they also highlight areas for potential improvement to overcome challenges related to study design and implementation of the intervention (see below).

[19] EXCLUSIVE: Average EAP usage reaches 12% for 2022 - Employee Benefits

[20] Deloitte report 2022

Topics for further research

A larger trial, incorporating more participants, is recommended to evaluate the effectiveness of the REST intervention. This would allow for greater generalisability of the findings. Furthermore, the qualitative findings suggest that the programme could be rolled out more widely to promote positive wellbeing for all employees, not just those with existing mental health concerns. Additionally, a future trial could measure platform analytics to allow examination of how engagement with the intervention predicts symptom improvement.

Links to more information:

Patel K, Moukhtarian TR, Russell S, Daly G, Walasek L, Tang NKY, Toro C, Meyer C. Digital cognitive behavioural therapy intervention in the workplace: Study protocol for a feasibility randomised waitlist-controlled trial to improve employee mental well-being, engagement and productivity. BMJ Open. 2022 Dec 9;12(12): e060545. doi: 10.1136/bmjopen-2021-060545. PMID: 36600345; PMCID: PMC9743318.

Moukhtarian, T. R., Fletcher, S., Walasek, L., Kershaw, C., Patel, K., Hurley-Wallace, A. L., Russell, S., Daly, G., Tang, N., Toro, C., & Meyer, C. (2023). *A mixed-method randomised controlled feasibility trial of digital CBT and emotion regulation skills training for employees in the workplace (REST)* [Preprint]. In Review. https://doi.org/10.21203/rs.3.rs-3120311/v1

5.3.2.2 REST 2.0

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 wider economy, there is a demand for preventative approaches to strengthen individuals' protective characteristics (e.g., resilience, emotion regulation skills) against poor mental health outcomes.

Summary of key adaptations

The Reducing Stress in the Workplace (REST) programme was developed by researchers at the University of Warwick. A feasibility study for the REST programme was previously conducted (Moukhtarian et al., 2023) and changes to the intervention were made to incorporate participants' feedback.

Eligibility criteria for the intervention was extended to include any employee who feels they might benefit from learning coping skills to improve their resilience and wellbeing to address the need for preventative workplace wellbeing interventions. The feasibility study required participants to score above non-clinical thresholds on either depression or anxiety scales. In addition, based on feedback received through interviews, additional optional modules were incorporated in the intervention (e.g. specific resources for working parents, those who may have money problems affecting their wellbeing, women in menopause), as well as an integrated webchat function on the intervention platform so participants can have accessible open channels of communication with the research team.

This study evaluated the efficacy of the revised REST 2.0 intervention, an integrative 8-week digital psychological skills training intervention, on improving measures relating to wellbeing and organisational outputs. Participants were randomised to the intervention group or waitlist control group and completed outcome measures at pre-intervention, post-intervention and three months follow-up, with self-efficacy as the primary outcome measure. Secondary outcomes explored changes in levels of wellbeing and organisational outputs.

Summary of key findings

398 participants completed the baseline survey, with 208 participants from the intervention group and 190 from the WLC group. Of the 398 participants, 192 participated in the 8-week survey (48.2%), with 60 from the intervention group and 132 from the WLC. Of the participants who were initially allocated to the intervention (n = 208), 36 (17.31%) completed the 3-month follow-up survey. Most participants were female (87.2%), in the 40-49 years age bracket (34.2%) and of white ethnicity (88.4%).

There were significant differences in mean scores between the intervention and WLC groups on the primary outcome of self-efficacy at post-intervention, with participants from the intervention group displaying improved and higher levels of self-efficacy. There were also significant differences on secondary wellbeing outcomes of emotion regulation, perceived stress, wellbeing, depression, anxiety, resilience and positive wellbeing and fulfilment, in favour of the intervention group. There were also significant differences in mean scores of general job satisfaction at post-intervention, with participants from the intervention group displaying higher levels of job satisfaction, however there were no significant differences on other organisational output measures. On examining changes in outcomes over time (post-intervention and 3-month follow-up) for the sample (i.e., once WLC participants completed the intervention as well), significant improvements were observed over time for all outcomes except for work performance and turnover intention.

Key conclusions and impact

The findings indicate that implementation of a digital psychological skills training intervention in the workplace may be beneficial on a wide range of wellbeing outcomes, however there is less evidence for the effectiveness on organisational outputs, specifically work performance and turnover intention. There is also preliminary evidence for the sustained effects of the intervention over the short term however, due to the small sample size at follow-up, the interpretation and generalisability of the findings are limited, and the longer-term effects remain unclear.

Topics for further research

- Long-term effects of the intervention on health, positive wellbeing and work productivity outcomes
- Cost effectiveness of psychological skills training intervention in the workplace

Link to more information

Moukhtarian, T. R., Fletcher, S., Walasek, L., Kershaw, C., Patel, K., Hurley-Wallace, A. L., Russell, S., Daly, G., Tang, N., Toro, C., & Meyer, C. (2023). *A mixed method randomised controlled feasibility trial of digital CBT and emotion regulation skills training for employees in the workplace (REST)* [Preprint]. In Review. https://doi.org/10.21203/rs.3.rs-3120311/v1

Patel, K., Moukhtarian, T. R., Russell, S., Daly, G., Walasek, L., Tang, N. K. Y., Toro, C., & Meyer, C. (2022). Digital cognitive behavioural therapy intervention in the workplace: Study protocol for a feasibility randomised waitlist-controlled trial to improve employee mental well-being, engagement and productivity. *BMJ Open*, *12*(12), e060545.

5.3.2.3 SLEEP

Insomnia is defined as frequent difficulties in falling asleep and/or staying asleep for at least three months, with around 10% of the general population experiencing these symptoms. Research suggests insomnia is associated with increased rates of occupational accidents, absenteeism, presenteeism, burnout and reduced productivity. In turn, these factors contribute towards a £50 billion cost to the UK economy every year because of lost working days. The workplace has been identified as a strategic place to address this growing public health concern, by offering a sustainable, accessible setting to deliver timely, preventative support. As part of the wider MHPP programme, working individuals from across the Midlands region were recruited to take part in several evidence-based pilot trials.

The SLEEP programme was developed by researchers at the University of Warwick, an eight-week digital hybrid cognitive behavioural therapy for insomnia (CBT-I) and emotion regulation delivered via the workplace. The intervention incorporated self-guided psychoeducation from a web-based platform with 4 videoconferencing therapy sessions, where a trained CBT-I therapist supported employees through various behavioural, cognitive, educational, and emotion regulation (e.g. relaxation) components.

Following a randomised waitlist-controlled trial design, 80 participants were randomly allocated to the intervention group and 79 to the waitlist-control (WLC) group, who received the intervention after an eight-week delay. Utilising validated questionnaires (i.e. measuring symptoms of insomnia, anxiety and depression), self-reported sleep diary data and actigraphy data (e.g. metrics from a wearable sleep tracker device), the efficacy of delivering the SLEEP intervention via the workplace was investigated. These measures were administered at baseline (pre-intervention), end of treatment (week eight), as well as short- and long-term follow-up timepoints, to understand any immediate and sustained improvements in symptoms of insomnia, anxiety and depression. 21 participants also took part in an interview, to better understand their experiences of the intervention, including barriers and facilitators to engagement, behaviour change mechanisms and contextual factors that shaped outcomes.

Summary of key findings

159 participants took part in the study (mean age = 43 years; 77% female; 81% white), demonstrating overall good engagement with the SLEEP intervention (mean online platform completion = 73%; mean therapy appointments attended = 3.4/4). Participants in the intervention group showed significant improvements in symptoms of insomnia, anxiety and depression compared to the WLC group at the end of treatment. There was a 45% reduction in the percentage of participants in the intervention group meeting clinical criteria for insomnia at the end of treatment, with similar reductions found for depression and anxiety (~30%), compared to 3% and 10% respectively in the WLC group. Participants also experienced significant improvements in overall wellbeing, as well as outcomes from the self-reported sleep diary data (e.g., sleep efficiency, proportion of time spent asleep in bed relative to total time spent in bed). However, there were no significant improvements in work-related productivity outcomes, job satisfaction, quality of life or actigraphy data.

Interviews with participants endorsed these findings, with participants discussing predominantly positive experiences of the SLEEP intervention and suggested a 'spill over' effect of sleep improvement on overall wellbeing. Therapist support and access to private space were indicated as particularly important factors to facilitate engagement with the programme.

In summary, the SLEEP programme has been evidenced to be highly effective when delivered via the workplace, significantly improving symptoms of insomnia as well as demonstrating wider improvements in depression, anxiety and overall wellbeing.

Key conclusions and impact

The results of this study build upon previous research, adding to the substantial existing literature on the effectiveness of CBT-I in reducing symptoms of insomnia. In addition, the improvements in symptoms of anxiety and depression have been demonstrated above and beyond what is seen in the literature for similar digital interventions. Furthermore, SLEEP has 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.

Topics for further research

To better understand the cost-effectiveness of the SLEEP intervention and any potential cost benefits, a larger trial would be recommended by further evaluating the impacts of the intervention on productivity-related outcomes. Future research should seek to better understand the incongruence found on improvements between self-reported sleep diary data and actigraphy, to ensure that any

parameters used to test the effectiveness of future interventions are reliable and validated. Any future study should also aim to recruit a more diverse sample to better represent males and individuals from racial and ethnic minority groups, to ensure the findings can be generalisable across different sociodemographic groups.

Link to more information:

Moukhtarian, T. R., Patel, K., Toro, C., Russel, S., Daly, G., Walasek, L., Tang, N. K. Y., & Meyer, C. (2022). Effects of a hybrid digital cognitive–behavioural therapy for insomnia and emotion regulation in the workplace (SLEEP): study protocol for a randomised waitlist control trial. *BMJ open*, **12**(7), e058062.

Moukhtarian, T., Fletcher, S., Walasek, L., Patel, K., Toro, C., Hurley-Wallace, A. L., Kershaw, C., Russel, S., Daly, G., Tang, N. K. Y., & Meyer, C. (2024). Effects of a hybrid digital Cognitive Behavioural Therapy for Insomnia and Emotion Regulation in the workplace (SLEEP): Results of a randomised waitlist-control trial.

Hurley-Wallace, A., Patel, K., Tyerman, S., Moukhtarian, T., Toro, C., Daly, G., Russel, S., Walasek, L., Tang, N. K. Y., & Meyer, C. (2024). "Better sleep, better wellbeing": Qualitative process evaluation of hybrid digital Cognitive Behavioural Therapy for insomnia + Emotion Regulation intervention for employees with sleep problems

5.3.2.4 BITE

Context

Eating disorders involve unhealthy eating behaviours like restriction, binging, or getting rid of food through exercise, laxatives, being sick, and other unhealthy means (purging). Contrary to mainstream stereotypes, individuals do not have to be under-weight to experience an eating disorder.

In 2019, there were reported to be 55.5 million cases of eating disorders worldwide, imposing significant economic costs. Research shows working-age young adults with eating disorders are less likely to seek help compared to adolescents. There is a growing body of research for the effectiveness of Cognitive behavioural therapy (CBT)-based interventions offered within the workplace, also improving productivity and overall mental health, although specific workplace-based eating disorders interventions are lacking. Therefore, it is crucial to address barriers to treatment access for working-age adults.

CBT for eating disorders (CBT-ED) is a well-researched, effective treatment for eating disorders – but is costly, requiring up to 20 hours of specialist clinician time per client. A shorter, ten session treatment for non-underweight eating disorders (CBT-T) has been more recently developed and tested within healthcare settings and has been found to be just as effective as traditional CBT-ED.

The BITE (Brief Individual Treatment for Eating Disorders) trial, a collaboration between University of Warwick and a Senior Eating Disorders Clinician, aimed to assess the feasibility of offering CBT-T in the workplace. Eligible employees with disordered eating received ten sessions of online CBT-T and two follow-up sessions. Regular measures of eating disorder, anxiety and depression symptoms, and work productivity were collected, alongside a Participant Experiences Questionnaire.

Summary of key findings

Recruitment, Attrition and Attendance

47 participants were recruited to the trial, exceeding the target of 40 participants set for high feasibility. 61.7% of these participants completed treatment, with 98.2% attendance, confirming high acceptability of the CBT-T delivered through the workplace.

Participant Experiences

24 therapy completers also completed a Participant Experiences Questionnaire. Findings indicated work or workplace (e.g. demanding workload) as triggers for their disordered eating. Many reported that receiving therapy at work enhanced accessibility to treatment, engagement, and improved their focus and productivity. Participants noted positive outcomes on eating disorder symptoms, mood, and energy, and praised therapist characteristics.

Effectiveness of the therapy

Statistical analysis of symptom and productivity measures showed that participants experienced reductions in eating disorder symptoms, anxiety, depression and work-related impairments. However, no significant differences were observed in absenteeism or work time missed. Over the follow-up period, there were no signs of substantial deterioration – on the contrary, there were further improvements in eating attitudes.

Participants who initially met potential criteria for an eating disorder diagnosis (n=24), and completed the therapy, all met the full remission criteria i.e. could be classed as "recovered"; and eight of the eleven participants who attended the final follow-up session continued to meet remission criteria. Participants who were classed as "sub-threshold" initially (i.e. did not display clinical levels of eating disorders) also showed good recovery rates.

In summary, the brief individual treatment for eating disorders (CBT-T) delivered through the workplace is highly feasible and acceptable, with participant experiences further adding to the acceptability. Preliminary effectiveness of the therapy is also considered promising, although a larger, controlled trial (RCT) would need to be delivered to establish full effectiveness estimates.

Key conclusions and impact

Brief Individual Treatment for Eating Disorders (CBT-T) accessed via the workplace is feasible, acceptable and potentially very effective. This approach could lead to earlier provision of interventions and lower pressure on mental health services.

Topics for further research

The findings from this study provide a strong rationale for a larger, randomised control trial to determine the effectiveness of CBT-T in the workplace. Further research should also seek to demonstrate that this approach can work across sociodemographic and economic settings, by recruiting a more ethnically and socially diverse range of participants from a wider range of workplace settings (e.g. those that are not able to work from home, or regularly have access to a laptop).

Recommendations

Following the success of the BITE trial, we propose that a larger scale trial be delivered to further understand the effectiveness of CBT-T in the workplace setting on reducing symptoms of eating disorders, anxiety, depression and work-related impairment. Given the potential scope for scalability and sustainability of such a model of intervention delivery, it would be important to understand any long-term health and wellbeing benefits to the individual, as well as any cost benefits to employers, industries, the national health care system and the UK economy.

Links to more information

Toro, C. T., Jackson, T., Payne, A. S., Walasek, L., Russell, S., Daly, G., Waller, G., & Meyer, C. (2022). A feasibility study of the delivery of online brief cognitive-behavioral therapy (CBT-T) for eating disorder pathology in the workplace. *International Journal of Eating Disorders*, *55*(5), 723–730. https://doi.org/10.1002/eat.23701

Toro, C. T., Payne, A., Jackson, T., Russell, S., Daly, G., Waller, G., & Meyer, C. (2023). Evidence for feasibility of implementing online brief cognitive-behavioral therapy for eating disorder pathology in the workplace. *International Journal of Eating Disorders*, *56*(6), 1254–1268. https://doi.org/10.1002/eat.23961

6. Discussion points

Building on MHPP1.0, the objectives for MHPP2.0 were set which included:

1 To develop a universal set of minimum data variables, founded on robust academic methodology, that enable baseline and post-intervention data collection and data analysis across all interventions.
2 To target engagement and promotion to suit organisations of different types (including different sizes, different sectors and from different locations).
3 To provide individualised support to organisations who do not currently have a strong understanding of their workplace mental health and wellbeing needs. This is key since organisations are more likely to engage when they have this understanding.

The Enhanced Offer was developed to meet these objectives. A universal set of minimum data variables was developed which included SWEMWEBS, PHQ9, EQ5D-5L and questions to elicit information to change against the HSE Management Standards. Other data was collected which included but not exclusively, demographics, wage levels, position in the organisation, type of contract and whether they worked in the workplace, hybrid or homeworker.

As articulated before, MHPP has worked with organisations of various sizes, sectors and types and the learning below demonstrates the feasibility of the intervention on these. It was evident that all of the organisations who engaged with MHPP were at various levels of maturity on their mental wellbeing journey.

Organisational level

MHPP has been operating for four years with an aim of unlocking 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. We have identified that this is an extremely complex subject matter.

Throughout the programme partners have worked on various versions of customer journeys and engagement routes. **There is no 'one size fits all' or 'silver bullet' in this space** and the approaches have had varying levels of success, reinforcing the view that it remains challenging to design such a programme for a national level audience. MHPP has however successfully contributed to a social movement approach to promoting mental health and wellbeing in the workplace with a parity of esteem with physical health and safety in the workplace.

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

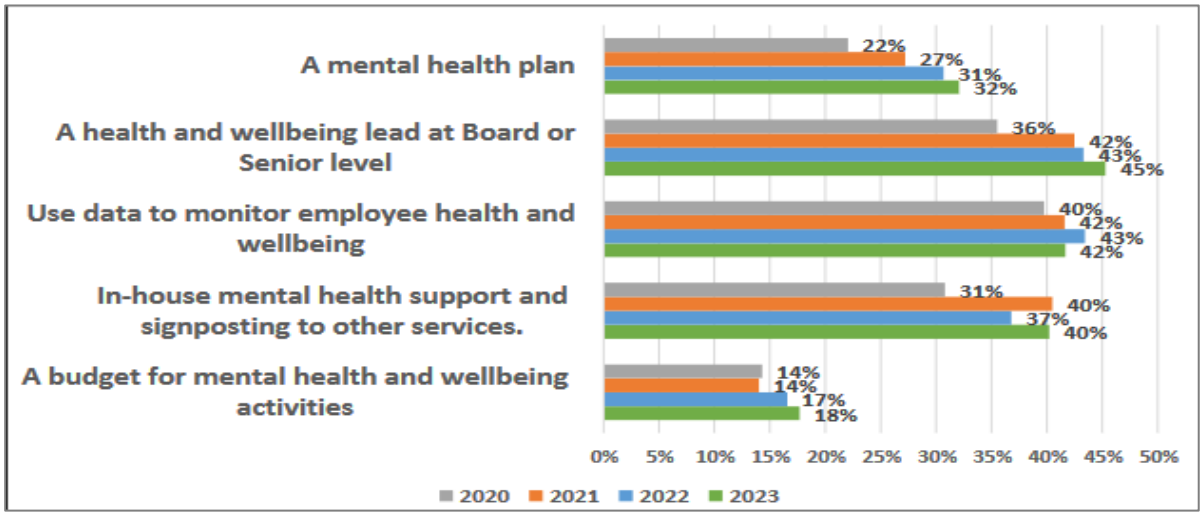
Despite interest from employers wishing to take part in the programme in the early days (Sept 2020), significant work was needed to convert that initial interest and engagement into sign-up and participation. Despite the offers being free at point of delivery, this was a significant challenge for all the research and delivery pilots. y. It 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. It is also recognised that this was a particular challenge for the Thrive at Work and the Mental Health at Work Commitment delivery teams who, despite having trusted brands, were challenged with recruitment levels and speed.

The study has identified that whilst organisations are seeing the importance of workplace wellbeing, budget 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.

Data from the ERC's report (2023) *Workplace Mental Health in Midlands firms 2023: A longitudinal study report* (Figure 9) shows the stubborn level of growth by only 4% over four years of organisations willing to invest in a budget for health and wellbeing activities.

Figure 9: Proportion of firms with strategic initiatives (ERC data on all firms, 2023)



However, it is noticed that despite the lack of investment by organisations there has been positive movement in the Midlands organisations with a **10% increase in firms having a mental health plan and 9% increases in senior leadership engagement and in-house support or signposting** to other services to be offered.

MHPP identified through the qualitative and quantitative research undertaken though the Enhanced Offer that the **workplace *is* an environment where positive changes can be made**, and impact seen in a short space of time. Whilst it is recognised that the evidence is not strong to suggest that workplace interventions lead to improved health outcomes in the short term; the emerging evidence does suggest the cultural shifts are being made, which in turn - over time - could lead to improved health outcomes[21].

One consideration that the researchers identified when working with organisations, was that although the framework or offer of intervention may be free at point of delivery, it did require the organisation to commit resources to support adoption and implementation. Whether that be members of the HR team, wellbeing leads or senior lead, an individual or team of staff were needed to implement the programme and assist staff to deliver the intervention. In addition, it is also 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) has been instrumental in supporting the journey for many organisations. Although a time limited resource, the evidence suggests that this **hand-holding support** has helped organisations to move the agenda further and faster.

[21] Diener, E., & Chan, M. (2011). Happy people live longer: Subjective well-being contributes to health and longevity. Applied Psychology: Health and Well-being, 3, 1-43. 5 and
Epel, E. S., Blackburn, E. H., Liu, J., Dhabhar, F. S., Adler, N. E., Morrow, J. D. et al. (2004). Accelerated telomere shortening in response to life stress. PNAS: Proceedings of the National Academy of Sciences, USA, 101, 17323–17324

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 interventions when individuals were absent on leave or through sickness which left a void for the delivery teams. It was identified that good organisations created multiple leads and created wellbeing champions to minimise this and shared 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 their 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 have created new learning which can support line managers to be deal more effectively with this at an earlier stage, ultimately reducing the potential for extended sickness absence and staff turnover due to ill health.

MHPP recognised how **difficult this landscape is for organisations to navigate, in terms of data**. Unlike most organisations and business processes where evidence is used to 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. Fundamentally, **organisations are awash with data**. On average 42% of firms use data to monitor the health and wellbeing of staff. However, we 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 areas that the data identified. This was most notable in relation to 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 University of Warwick, one of the barriers included the **reluctance to reduce mental health experiences to statistics** and a perception that reporting on collected data may be more relevant for larger organisations and being unable to prioritise it. There was one organisation that stated that to prevent data collection from becoming a mere tick-box exercise, the process should be measured externally to implement a level of accountability. In fact, 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 persistently highlighted that the data that is collected plays a crucial role in shaping mental health strategies, informing action planning at both employee and senior leadership levels. Linking to the quantitative survey findings however, over 1/3 of organisations (36%) did not feel they have the expertise to analyse mental health data and form 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.

"So we have some kind of data and measure and then as I said, quarterly review the six standards and we review what objectives we set in the previous quarter, to check whether we've met them or why we couldn't meet them if we didn't meet them, and to set the next quarters objectives as well and then we have, all the Mental Health first

aiders have specific subsections that they look after and they always, they have actions on their action spreadsheet to achieve as well."-Interview 3

"We've got more robust because we've got the Commitment and some of the questions talk about that. We've got more robust at the…and at the…sickness absence monitoring, generally we needed to get more robust and that's been helpful and the wellbeing officers reporting in there how many calls has been a new thing that I've introduced so that we've got some data to be able to report into the standard."- Interview 5

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

Throughout MHPP, **availability of data is a significant challenge**. Organisations are not required to maintain data in relation to workplace wellbeing and as such there was a plethora of approaches being taken or in some cases none. The researchers identified several organisations who 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 generally larger in size who 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 is inputted. Organisations generally 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, Great Place to Work survey to name but a few. Our analysis shows a level of **survey fatigue from employees**. Our analysis also found that staff did not always hear back from the results of the surveys, so they felt undervalued and not worth taking the time to complete. As part of the MHPP Enhanced Offer employers were given the tools to ensure that results where shared and requested that they were posted on intranets or within the organisations. In additions the Engagement Officers undertook feedback sessions on behalf of the organisation as the independent researchers.

The programme recognised the **value of data as a tool to support the identification of relevant interventions**. Data is required 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 but the survey questions leading to the creation of the MHPP Status Report provided a strong basis to work from. These include validated questions; including but not exclusively, SWEMWEBS, the 6 Management Standards, awareness and confidence of dealing with mental health and sickness absence. It is important that, employee surveys are undertaken purposely. A smaller set of validated questions should be used to reduce the impact on employee time and reduce the feeling of survey fatigue.

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, occupational health advisor or develop a structure in the organisation which tackles the main contributors of workplace health? MHPP worked with partners to develop an evidenced 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 suggests that the extra support from the Enhanced Offer has been helpful for employers which c56reated 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 initial findings 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, on their own don't provide a strategic long-term solution that is rooted in promotion or prevention interventions or tackle the causes of workplace stress through the tackling the challenges identified within the 6 HSE management standards.

Employee level changes

MHPP has worked primarily with employers to shape their improvement to workplace mental wellbeing. It is 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 wider economy, there is a demand for preventative approaches to strengthen individuals' protective characteristics (e.g., resilience, emotion regulation skills) against poor mental health outcomes.

As can be seen from the individual level pilots we have seen 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.

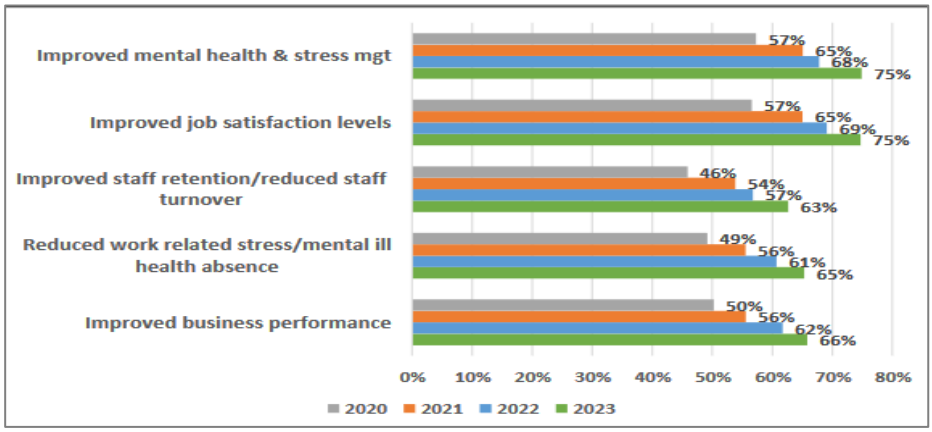
- MENTOR demonstrated through the quantitative analysis that psychological distress significantly decreased, whilst productivity, work engagement, psychological flexibility, and interpersonal relationships all significantly increased from baseline to post-intervention.
- It also identified that stress 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; d=1.7 for insomnia, d=1.6 for depression and d=1.2 for anxiety. Whilst the intervention did not show 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 10, 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 10: Reported impacts of mental health activities in all firms (ERC data, 2020-23)



7. Conclusions

MHPP has worked across the Midlands region for four years to support organisations to create mentally healthy workplaces. The evidence shows big shifts in relation to the adoption and implementation of workplace mental wellbeing plans and strategies and the green shoots of employee outcomes in a short space of time (see SLEEP, REST and MENTOR 2.0 for mental health and productivity) and movement on core root of HSE drivers of workplace stress as part of wider framework of focus.

Change is happening and momentum has been built. We are proud of the level of work that has been undertaken during this time through the research team, extended expert reference groups, strategic stakeholders and of course the businesses and organisations who have been on the wellbeing journey with us.

It is recognised that the productivity puzzle is yet to be solved however we now have one of the first data sets that forms a baseline linking both employee and employers, and we have seen great advances in employer policy, practice and actions alongside outcomes and indicators that inform employee change.

We have demonstrated that the workplace is a worthwhile setting that does improve wellbeing outcomes (REST, SLEEP) and though there is limited generalisability around work outcomes and productivity (except MENTOR 2.0) - this is a place to build from.

We are further forward in the knowledge of what works and what does not work especially in relation to engaging organisations, motivations for engagement and activities that organisations can deliver with or without support. All of this contributes to the social movement approach to promoting mental health and wellbeing in the workplace whereby the aim, ultimately, is to achieve parity of esteem with physical health and safety in the workplace.

However, this opens the wider debate as to who should fund workplace health interventions. The MHPP programme was funded by the Midlands Engine through funds secured from the DWP (Department for Work and Pensions) and DHSC to explore if improvements in the workplace health system could reduce the burden on the wider health and social care system. The Enhanced Offer alone has not necessarily been able to establish this with an evidence base in the time available, but we have demonstrated how support and interventions at work can drive outcomes.

However, as described earlier, the work is suggesting that organisations should embed workplace health and wellbeing interventions to support the health and wellbeing of their employees. As identified through the natural experiment, workplaces can see a return on investment of £1.29. This should be seen as the minimum ROI. The evidence suggests that the low and medium intervention offer provided sufficient support to move the programme further and faster than the unsupported MHAW offer by up to anytime from one year to eighteen months[22].

The power of regional collaborations should also be recognised that have been generated through the MHPP pilot. The programme team working with Strategic partners such as the Midlands Engine, West Midlands Combined Authority, Office of Health Improvements and Disparities, Mind, and local Integrated Care Boards have galvanised partners and organisations towards a common goal, creating a social movement of action. It has created a platform for discussions on workplace mental wellbeing to take place at regional level, local level and within organisations and communities. It has harnessed the power of anchor institutions, such as the NHS, Universities and large employers to influence change through engagement and with some directly leading by example.

MHPP has generated significant learning to share with organisations and statutory bodies to support future work in the wellbeing space. We recognise that there is a fine balance here as many employers (and therefore individuals and the economy) have benefitted from the free support provided by MHPP as part of the offer. Investment will continue to be a key challenge, but additional work is essential to

[22] Mental Health at Work Report

identify the 'sweet spot' between investment and impact. Whilst it is recognised that the current fiscal landscape may not provide sufficient encouragement for organisations to see this as core business, it is hoped that this learning will provide a nudge to those organisations who wish to stand out from the crowd and show that they care about their staff.

8. Recommendations

8.1 Employee level interventions

1. Based on the findings of this study, we propose the REST intervention is adapted to have a preventative focus aiming to promote positive wellbeing, thus making it appropriate and beneficial to an entire workforce. Furthermore, qualitative feedback suggested that the lack of human contact during the intervention may have contributed to the relatively low engagement rate of 50%. To account for this a future version of REST may benefit from further light touch support approach (either therapist lead or peer support.
2. A trial with longer follow-ups is recommended to evaluate whether there is a sustained effect of the REST intervention. An understanding of high attrition rates observed would assist in any future development or implementation of a digital psychological skills training intervention in the workplace.
3. Following the success of the SLEEP intervention on improving symptoms of insomnia, anxiety and depression, we propose the SLEEP intervention is replicated on a larger scale, to better understand any work-related productivity implications. Given the potential scope for scalability and sustainability of such a model of intervention delivery, it would be important to understand any long-term health and wellbeing benefits to the individual, as well as any cost benefits to employers, industries, the national health care system and the UK economy.
4. Employment Liaison Worker Pilot - Work closely with employers to drive engagement, manage client expectations, and champion employee and manager participation in the service in a timely way.

   Consider ways to improve communication between Mental Health Employment Liaison Workers (MHELWs) and clients to organise sessions more efficiently and emphasise their importance to help reduce the number of rearranged or cancelled sessions.

   Continue to use feedback and insights from key stakeholders to address wider challenges around service delivery to inform and shape future development of the service model.

   MENTOR 2.0 intervention appears to be a promising approach for improving psychological health in the workplace. The significant reductions in psychological distress and improvements in other work-related outcomes provide a strong basis for further research. Future iterations of the programme could benefit from reviewing the identified limitations, including diversifying the participant pool, simplifying the workbook, reducing the survey burden, and incorporating follow-up sessions to sustain the intervention's benefits and build understanding around the generalisability of the model.

5. Organisations, particularly small and medium enterprises (SMEs), should consider integrating MENTOR 2.0 into their employee wellness programmes. Our findings highlight the continuing need for training programmes that help managers understand and effectively address the mental health needs of their employees and the importance of employee-manager relationships being supported in this process.

   Policymakers should consider the evidence from this study to support the adoption of comprehensive mental health programmes (that include training for both employees and managers) in workplaces and the importance of providing independent tailored support for employees and their managers so workplaces support people to be at work well.

6. Sufficient confidence exists in PROWORK despite a lack of evidence due to small sample size in the pilot trial. Based on feedback from participants in the pilot trial and from the additional studies, PROWORK could be seen as a strategic part of the MHPP offer. Continue to recommend to employers. Plan and enact initial work required to bolster evaluation evidence.
7. The Managing Minds at Work digital learning can be used to improve line manager knowledge, confidence and competencies.

   MMW+ shows potential for increasing engagement and developing action plans, but larger-scale testing is required.

8.2 Organisational recommendations

8. Mental Health at Work - Continue to support organisations and partners to raise the floor (minimum standards) and the ceiling (best practice standards) of workplace wellbeing through investment in a national framework supported by a digital scalable intervention model of support alongside regional consultative hubs. This should include a central one stop shop for trusted, quality assured best practice workplace mental health information so employers have confidence of where to go for information and guidance.
9. If MHFA is adopted in workplace settings, it should be done so as a mental health literacy intervention and accompanied by other necessary interventions to appropriately support the mental health of employees.
10. Thrive at Work – Regional Combined Authorities have the opportunity to support improved productivity by supporting organisations to invest workplace wellbeing. Further roll out of workplace wellbeing initiatives should be considered using Thrive at Work as a potential blueprint.
11. Move beyond mental health awareness campaigns and mental health first aid. Many organisations had put in place tools to support employee health but had not taken broader actions. As there was an increase in activity across all standards and across all organisations this suggests that the lack of activity in other standard areas may be due to a lack of awareness of alternative actions and how to implement them, rather than more complex barriers to implementation. Policy makers, professional and employer bodies and charities should seek to expand the messages shared to employers to encourage a broader set of actions to improve health and wellbeing.
12. Make it a requirement for there to be a designated person at board level with responsibility for mental health and wellbeing. The action 'Designated person on senior leadership or board level with responsibility' saw the highest percentage change. This suggests organisations were able to make a positive shift on this action quickly and with limited resistance. Research has consistently demonstrated the vital role of support from senior leadership.
13. Provide employers with an opportunity to assess their status via tools and reports so that they can take positive action. The percentage change reported in the natural experiment indicates that once aware of gaps in provision, organisations are able and willing to take positive action.
14. Provide employers with support to identify appropriate action. Support from engagement officers enabled organisations to take a strategic and proactive approach. Research shows that this kind of approach is vital for improving and sustaining employee health and wellbeing at work.

15. Encourage employers to triangulate data: policies and practices, employees experience of work and employee health. Previously, these activities have been promoted in isolation. The Standards (e.g., by Mental Health at Work, BITC, Thrive at Work); the experience of work (e.g., HSE Management Standards), and employee health (e.g., EAP (Employee Assistance Plan) reports, engagement in health apps). Considering all sources of information simultaneously provides employers with a more granular and complete data overview on which to make decisions about necessary changes. MHPP has been seen as a unifier across the Midlands and demonstrates the power of working at regional level on this agenda.
16. Extend the duration of organisational research studies. Findings demonstrate small uplifts across most of the markers including the Standards, work dimensions, and health outcomes. However, i) engaging organisations in data gathering exercises such as used in MHPP and ii) deciding on and taking action to change policies, processes and culture take time. Future research studies would benefit from taking a longer-term approach (with stop clauses if there are concerns for funding utilisation).

Appendix A: List of individual reports from all aspects of MHPP

A. Engagement and Communications Report (Engagement and Communications Group)

B. Mental Health at Work Report (Mind)

C. Mental Health at Work Academic Evaluation Report (University of Warwick)

D. Thrive at Work Report (WMCA)

E. Natural Experiment Final Report (Coventry University)

F. MENTOR Final Report (University of Birmingham and Mind)

G. PROWORK Final Report (Loughborough University)

H. Managing Minds Final Report (University of Nottingham)

I. Mental Health First Aid Evaluation Report (University of Nottingham)

J. This is Me Evaluation Report (Loughborough University)

K. REST1 Final Report (University of Warwick)

L. REST2 Final Report (University of Warwick)

M. SLEEP Final Report (University of Warwick)

N. SLEEP Qualitative Process Evaluation Report (University of Warwick)

Appendix B: Independent evaluations of MHPP

O. MHPP 1.0, 2022 (Traverse)

P. MHPP 2.0, 2024 (Cordis Bright)