Supporting occupational health and wellbeing professionals

Working with the CIPD

The value of Occupational Health and Human Resources in supporting mental health and wellbeing in the workplace

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FOREWORD

The issues around mental health in our society are pressing, and this of course also manifests itself in the workplace. We are seeing record numbers of days being lost due to work related stress, but there is also a significant burden of non-work caused mental ill health. There is therefore a need to support employees and colleagues in managing their mental health.

There are many interventions that are being publicised and sold to employers. It is however difficult to know what works. This guide is therefore necessary and timely, in reviewing the evidence base, to advise which interventions are effective.

This report provides OH and HR professionals and managers with the information they need to design programs and interventions for their organisations.

Dr Will Ponsonby
SOM Past President
November 2023

EXECUTIVE SUMMARY

Mental health and wellbeing interventions

With concerns around mental health and wellbeing growing amongst organisations, the challenge lies in how organisations can navigate this space to adequately support their staff – taking into account relevant good and evidence-based practice.

Here, Occupational Health (OH) and Human Resources (HR) each offer their own specialised expertise in relation to staff mental health and wellbeing, although better awareness and examples are needed to maximise the synergy between both functions.

Employers have the legal responsibility to ensure that work environment is safe, to carry out appropriate risk assessments, to make reasonable adjustments, and to have competent people responsible for the process.

The research evidence is also clear that better working environments are associated with better mental health and wellbeing, emphasising the need for interventions to take a more systematic approach. This means developing intervention activities that not only target the individual but strive to make improvement across how the workplace is deigned, organised, and managed.

While interventions can take many forms, they can typically take one of three forms:

- *Primary (prevention) interventions* aim to identify potential risks and hazards within the working environment to remove, reduce, or mitigate their effects. The emphasis here is typically on the working environment and the organisation.
- *Secondary (support) interventions* predominantly focus on the individual and aims to support them to improve their levels of self-care, to better manage their working environment, and to mitigate the effects of poor working conditions.
- *Tertiary (restoration) interventions* focus on the restoration and rehabilitation of workers struggling with their mental health and focus on the individual.

Taking a more systematic approach to support worker mental health and wellbeing means focusing on intervention activities that relate to the primary, secondary, and tertiary levels. This is in line with much of the research evidence demonstrating stronger and more long-term impacts when interventions take a more holistic approach rather than only targeting the individual.

Numerous frameworks and resources, including from the CIPD, the What Works Centre for Wellbeing, and the Health and Safety Executive, exist to structure and inform organisations of this process.

The role of Occupational Health and Human Resources across the intervention levels

As occupations focusing on people, both OH and HR play a pivotal role in supporting worker mental health and wellbeing. They offer unique strengths and expertise that should be drawn on.

At the primary (prevention) intervention level, OH can have an important role in the identification of potential workplace risks and hazards, and in monitoring occurrences of ill-health and injuries. For HR, their emphasis on developing and supporting the workforce relies on creating an environment that is conducive to the needs of the individual worker and the organisation.

In terms of secondary (support) interventions, OH can run interventions, carry out health screenings, and support the adjustment process for individuals and managers. Similarly, HR can run and develop awareness-related activities, facilitate access to further training and support, and develop and administer relevant policies and procedures.

With tertiary (restoration) interventions, OH can develop and administer pathways and the delivery of the treatment and rehabilitation of workers struggling with their mental health and wellbeing. HR can also support return-to-work programmes, individuals, and line managers; signpost to support services and rehabilitation services; and to manage Employee Assistance Programmes.

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The intention here is not to demarcate between the responsibly of OH and HR as there will be substantial variation and overlap in practice due to the abilities and experience of either functions. What is important is to recognise the limits of one's competence. There is also a need for OH and HR functions to work with each other and look to develop synergy, championing the contributions that OH and HR can make.

What can an organisation do?

To help organisations take a more systematic approach to support worker mental health and wellbeing, the following seven questions (with accompanying resources) can help organisations better structure this process:

1. *What are we looking to achieve?* Establishing what the organisation wants to focus on can help determine what needs to be done, particularly around assessing the working environment, and identifying any potential underlying risks and contributing factors towards the intended outcome.

2. *What are the factors that contribute to this?* Developing an evidence-based understanding of the current working environment and what the factors that that may facilitate or hinder the desired goal be. All this then helps create rationale and justification for change.

3. *Can we address these underlying factors?* The employer's responsibility means organisations should eliminate or address any of the risks identified within their risk assessments. Stakeholders need to be engaged to identify priority issues, possible solutions, and relevant resources.

4. *Can we support our workers with what they do?* Within a systematic approach, organisations must consider how to better support their workers. This means providing them with the knowledge, skills, resources, and abilities to manage their work tasks and environment.

5. *What is the evidence for the interventions being offered?* Decisions and actions to support mental health and wellbeing in the workplace should be evidence based.

6. *Who has the expertise to support us with this?* The work carried out must be done by appropriately qualified people. This can help ensure that interventions are grounded in good practice and the relevant scientific evidence base, and that there is protection to the workers and the organisation.

7. *How do we know this has or will work?* There is a need to evaluate interventions to see whether it made any difference and to consider any learnings from it. This can take the form of both outcome (did the intervention lead to any change?) and process (what happened during the intervention that might have affected the outcome?) evaluation.

Conclusion

As organisations are becoming better at recognising the importance of supporting staff mental health and wellbeing, it is imperative that interventions move beyond awareness raising and individual-focused activities, and instead take on a more systematic approach.

In doing so both OH and HR have much to offer, with this report showcasing examples and resources of how this has and can be done.

1. INTRODUCTION

Ever since publication of Dame Carol Black's report *Working for a Healthier Tomorrow*[1], there has been a much greater focus and awareness on worker mental health and wellbeing. This was further accelerated by Stevenson and Farmer's *Thriving at Work* report[2] that proposed a set of mental health core standards, before the COVID-19 pandemic further brought worker health and wellbeing to the forefront of organisational awareness.

In a recent survey by the CIPD[3] of 918 organisations, representing 6.5 million workers, 69% of HR professionals agreed that employee wellbeing is on senior leaders' agendas, and 67% believe that line managers have bought into the importance of wellbeing. Both findings have been part of a growing trend although senior level commitment has waned slightly since the height of the pandemic. Positively, 27% expect their wellbeing budget to increase slightly over the next 12 months while a further 4% predict it will increase significantly; the majority (63%) say it will remain the same..

However, the evidence indicates that work-related mental health continues to be an issue that organisations are struggling with. The most recent statistics from the Health and Safety Executive (HSE)[4] show that there were 914,000 cases of work-related stress, depression, or anxiety in 2021/22. This was equivalent to 17 million working days lost and made-up half of all working days lost due to work-related ill-health. The scale of the issue is further evident in the CIPD's 2023 Good Work Index[5], where one in four workers said that work is bad for their physical (26%) or mental (27%) wellbeing.

Worryingly, 19% of organisations admitted that they are currently not doing anything to improve worker health and wellbeing[3], and 36% reported being more reactive than proactive. Despite this, most organisations (76%) that report work-related stress absence are taking steps to address this, utilising good practice methods such as an employee assistance programme, flexible working options, staff surveys or focus groups to identify causes and risk assessments/stress audits.

Against this backdrop there has been a growing wellbeing industry to support organisations' increased focus on health and wellbeing. As a mostly unregulated area, products and services include those with a robust evidence base as well as pop psychology, misunderstood science, or nothing at all[6,7]. This makes it difficult for well-intentioned organisations to navigate this space effectively. Within organisations, there are also questions as to who is responsible for the health and wellbeing of workers. This often falls under the remit of Human Resources (HR) – who lack the medical health expertise, while Occupational Health (OH) may only have a restricted remit or might not be available at all.

Back in 2000, the HSE long-term strategy for OH[8] emphasised that OH practitioners had to work in tandem with other stakeholders for there to be an impact on workplace health while in 2005 the CIPD identified that OH and HR had to work together for workplace health to be effectively managed[9]. More recently, in 2019 CIPD and SOM published a joint article[10] to the same effect, which began:

> *Occupational health (OH) and HR practitioners represent the two professional groups most concerned with the health and wellbeing of people at work. As such, the strength of the working relationship between the two at a workplace level is critical, and yet we suspect most OH and HR professionals would acknowledge there is room for improvement. At the very least, it's time to evaluate whether a fuller appreciation of each profession's role by the other could encourage stronger collaboration to achieve the mutual aim of a more strategic and preventative approach to employee health and well-being.*

This aim also underpins this paper. It remains the case that many organisations are still uncertainty and confusion about the role that HR and OH have in relation to managing worker mental health and wellbeing, the value that they bring, and how best to work with each other[11–13].

This report provides an overview of the good practice guidance for managing mental health and wellbeing in the workplace, and the role that HR and OH have within it. It will first define mental health and wellbeing before covering the employer's responsibility, and then discussing how OH and HR fit into the process of developing primary, secondary, and tertiary-level interventions. Finally, the report poses six questions to help guide practitioners in this space develop better interventions to manage mental health and wellbeing at work.

1.1. What do we mean by mental health and wellbeing?

The World Health Organisation[14] defines mental health as a state of wellbeing in which an individual realises their own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to their community. It is more than the absence of mental disorders. It exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes.

Within the workplace, examples of the negative end of the continuum include work-related stress, depression, and burnout, with work engagement, happiness, and job satisfaction representing the positive end[15–17]. Within this, mental health also includes clinical diagnosable conditions such as depression, anxiety, and bipolar disorders.

Mental health is part of wellbeing, which is the fulfilment of the physical, mental, social, and cognitive needs and expectations of a worker related to their work[18]. Confusion can arise from the various definitions and frameworks around what wellbeing is. In addition, there are many terms related to wellbeing (e.g., thriving, flourishing, engagement) where there is little consensus on how to define and measure it[19]. This can be very problematic when approaches, expertise, and experience on managing certain aspects of wellbeing, such as employee engagement, are then applied to other aspects of wellbeing (e.g., depression, anxiety, neurodiversity).

The wellbeing field is littered with numerous fads and interventions that have little or no grounding. In an extremely lucrative industry with very little oversight there are unfortunately many providers and individuals marketing all sorts of remedies that claim to improve wellbeing[7,20]. A 2018 survey for Public Health England reported that most submissions on the impact of workplace health programmes were from intervention providers; that there was a disinclination to report negative findings; and that there was a lack of rigorous data collection and evaluation [21].

Further definitions and an overview of mental health and wellbeing are available from the CIPD/Mind guidance[106].

1.2. What are the factors that contribute to mental health and wellbeing?

The research evidence is clear that psychosocial working conditions are one of the key predictors of mental health in the workplace[17,22–24]. Psychosocial working conditions refer to how the workplace is designed, organised, and managed[25], and as Table 1 shows, they can take many different forms.

Table 1: Examples of psychosocial working conditions in the workplace[25]

Psychosocial factor	Examples
Job content	Lack of variety or short work cycles, fragmented or meaningless work, under use of skills, high uncertainty
Workload and pace	Work overload or underload, machine pacing, high time pressure
Work schedule	Shift work, night work, inflexible work schedules, long hours
Control	Low participation in decision making, lack of control over workload
Environment and equipment	Poor environmental working conditions, inadequate equipment
Organisational culture and function	Poor communication, low levels of support for problem solving and personal development
Interpersonal relationships at work	Social or physical isolation, poor relationships with superiors, interpersonal conflict, lack of social support
Role in organisation	Role ambiguity, role conflict, responsibility for people
Career development	Career stagnation and uncertainty, under or over promotion, etc.
Home-work interface	Conflicting demands of work and home, low support at home

When we look at the factors that predict mental wellbeing, psychosocial working conditions also emerge as key predictors. For example, drawing on the existing evidence available:

- What Works Centre for Wellbeing's Drivers of Workplace Wellbeing[26] contains five factors including: relationships (e.g., support from others, communication with line manager), security (e.g., safety, bullying), environment (e.g., working patterns, tools, fairness), and purpose (e.g., workload, clear goals);
- The CIPD's key domains of wellbeing[27] include: good work (e.g., work demands, autonomy, pay and reward), personal growth (e.g., career development), collective (e.g., employee voice), and values/principles (e.g., leadership, ethical standards);
- The CIPD's annual Job Quality Index provides an annual snapshot of job quality in the UK, giving insight to drive improvement in working lives. It captures data on seven dimensions of work to measure good work in the UK: pay and benefits; work-life balance; job design and the nature of work; relationships at work; employee voice; and health and wellbeing.
- Mind's Workplace Wellbeing Index[28] measures work factors including workload, work-life balance, line manager support, and physical work environment.

What this shows is that the underlying factors are similar. When trying to create and support mental health and wellbeing in the workplace efforts should consequently aim to be holistic and address these factors, which is covered in more depth in Section 2 of this report.

Organisations also need to recognise that employees' mental health and wellbeing will be influenced by factors in their personal lives. This means supporting people to manage the health impacts of wider wellbeing issues that they can experience through the employee lifecycle, (such as bereavement, domestic abuse, pregnancy loss, fertility issues, gambling harm, menopause, alcohol or drug dependency, caring responsibilities). Organisations may not be able to control these external events, but they can have a 'whole organisation, whole person' approach to health and wellbeing and make available support and adjustments to help people cope. The CIPD 2023 Health at wellbeing at work survey report finds that wellbeing support through the employee lifecycle is very variable in organisations[3].

1.3. What is the employer's responsibility?

The law is clear on an employer's responsibility with regards to **mental health**. According to the Health and Safety at Work Act 1974 and Management of Health and Safety at Work Regulations 1999 these include:

- Making sure the work environment is safe;
- Carrying out risk assessments as set out in regulations, and taking steps to eliminate or control these risks;
- Appointing a 'competent person' responsible for health and safety;
- Treating mental and physical health as equally important.

In addition, the Equality Act 2010 states that an individual with poor mental health can be considered disabled if:

- it has a 'substantial adverse effect' on their life (e.g., they regularly cannot focus on a task, or it takes them longer to complete tasks);
- it lasts, or is expected to last, at least 12 months;
- it affects their ability to do their normal day-to-day activities (e.g., interacting with people, following instructions, or keeping to set working times).

If an employee is disabled, employers must not discriminate against them because of their disability and must consider reasonable adjustments.

This makes it clear that the onus is on the employer to make **reasonable adjustments** to adapt the work to the worker, and not to expect the worker to need to adapt to the work. It also states the importance of **risk assessments** and the need for **competent people** to be responsible for health and safety – which includes mental health - within the organisation. More information is available in the SOM Value Proposition[7].

It is beyond the scope of this report to describe how the legislation applies to **mental wellbeing**, which has a broader and more nebulous definition. Instead, given that overlap between mental health and wellbeing and the similarities in the factors predicting them, taking a preventive risk management approach as advocated by law would be conducive for good mental wellbeing as well.

2. INTERVENTIONS TO SUPPORT EMPLOYEE MENTAL HEALTH AND WELLBEING

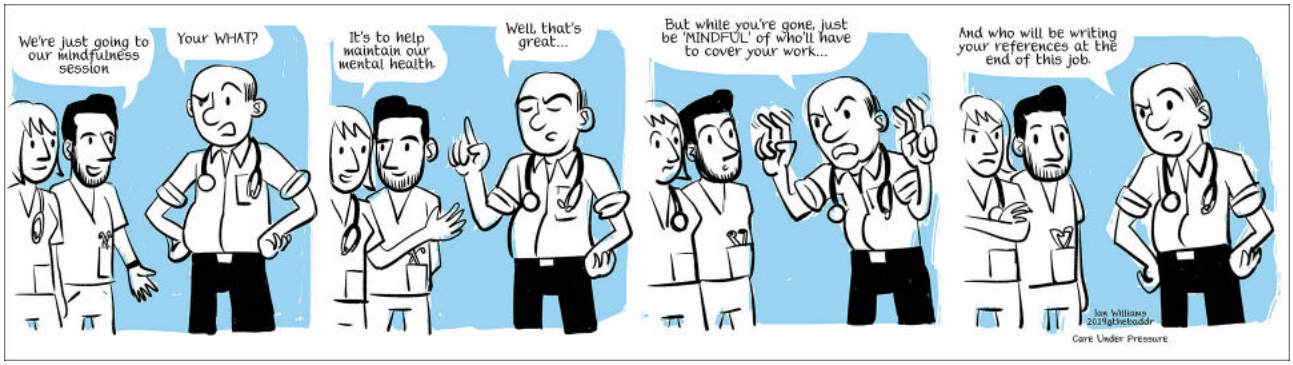
There are numerous ways mental health and wellbeing can be supported within an organisation. A useful framework in which to view this is where interventions are sorted into one of three levels - primary, secondary, and tertiary.

- *Primary interventions (prevention)* aim to identify potential risks and hazards within the working environment to remove, reduce, or mitigate their effects. This would typically include a form of risk assessment. For example, where workers are struggling with high workloads interventions would seek to reduce this to more manageable levels. This could be done through changing workflows and processes, reviewing how tasks are allocated, increasing levels of staffing, improving efficiency, or, possibly removing tasks which are not important or relevant. The emphasis here is on the working environment and the organisation.

- *Secondary interventions (support)* predominantly focus on the individual and aims to support them to improve their levels of self-care, to better manage their working environment, and to mitigate the effects of poor working conditions. The rationale is that this is achieved by individuals changing their thought patterns, attitudes, and behaviours, and can include training on psychological (e.g., coping, mindfulness, Acceptance Commitment Therapy) as well as technical (e.g., time management, technology) skills.

- *Tertiary interventions (restoration)* focus on the restoration and rehabilitation of workers struggling with their mental health (e.g., talking therapy, return-to-work programmes, treatment medication) and are therefore also focused on the individual.

Figure 1: Comic strip highlighting intervention failure (from the Care Under Pressure Project[40])



2.1. The effectiveness of different intervention types

In one study of 143 British organisations and 27,919 workers[29], workers that took part in individual focused interventions (e.g., mindfulness, resilience training, coaching, and wellbeing apps) were no better off in relation to multiple subjective wellbeing indicators. Instead, workplace factors such as being bullied, unrealistic time pressures, discrimination, and strained relationships had more influence and were associated with poorer subjective wellbeing. In contrast to the benign wellbeing impact of interventions focused on the individual, working conditions such as having the right training, choosing break time, being consulted on change, fair pay, fair promotions, flexible work, and good collaboration were all associated with better wellbeing.

This observation is further reinforced by other reviews of intervention studies[30, 31–33]. These generally show that interventions which focus on the primary level tend to have stronger effects than those who solely focus on individual level (i.e., secondary and tertiary). In one such example, a meta-analysis[31] of 19 studies involving 1,550 doctors found that, compared with individual interventions (e.g., psychoeducation, mindfulness), organisational interventions (e.g., shift pattern changes, improved teamwork, reduced workload) led to a greater reduction in burnout symptoms.

Given their aim of creating a better working environment for all, organisational interventions are generally more effective than individual interventions. The process of first identifying, and then either enhancing beneficial working conditions or removing adverse conditions, can create an environment that benefits not just an individual person, but a much broader group of workers. This is not only more consistent with an organisation's duty of care, but changes inherent in organisational interventions are far more likely to sustain, leading to a beneficial outcome over a longer period[30,33,34].

2.2. A systematic approach to mental health and wellbeing

What the research findings above highlight is that each intervention level has a different function, and that organisations should collectively draw on all three levels to develop a systemic and holistic approach to support mental health and wellbeing within it.

Here, organisations would use primary interventions to create the most conducive and healthy workplaces possible, using secondary interventions as supplementary activities to better equip workers to manage themselves, their wellbeing and their working environments. Tertiary interventions still have an important role to play – supporting individuals who may still be struggling and need support.

Crucially, this approach would see the emphasis being placed at the primary level, rather than using tertiary-level approaches as the main way to support workers. This is also consistent with an organisation's legal responsibility, which is to identify any risks to which an employee may be exposed, and taking appropriate measures to control these risks.

Managing and supporting worker health and wellbeing is not about piecemeal or specific interventions that are not part of a wider and more cohesive strategy. This is reflected in the comic strip in Figure 1. Ideally, these efforts should align with overall business strategy of the organisation and be factored into every operational decision made[35,36].

To support organisations to take an evidence-based approach, three contemporary frameworks to manage worker mental health are outlined below – the HSE Management Standards, the Mental Health at Work Commitment, and the ISO 45003 standards. These draw on the relevant research evidence on how best to manage worker mental health and have been developed by relevant subject-matter experts and bodies, in collaboration with employer groups and trade unions.

Through the frameworks below we begin to see the potential roles that Occupational Health and Human Resources have within the process of supporting mental health and wellbeing. This is then elaborated on in Section 3 and 4 of this report.

2.2.1. HSE Management Standards

Developed by the HSE, the Management Standards[37] are based on a strong research evidence base demonstrating the importance of 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 six areas are:

- *Demands* – the demands placed on the individual (e.g., workload, work patterns);
- *Control* – how much influence an individual has on the way they do their work;
- *Support* – the levels of encouragement, sponsorship and resources provided by various stakeholders (e.g., colleagues, managers, the organisation);
- *Relationships* – the quality of relationships, including levels of conflict and unacceptable behaviour;
- *Role* – how well individuals understand their roles and whether there is any conflict between tasks they are involved in;
- *Change* – how change within the organisation is managed and communicated.

The HSE provides a wealth of corresponding resources related to the Management Standards. These include questionnaires that can be used to support measurement and benchmarking of the six key areas, identifying and developing appropriate line manager behaviours, and running interventions to develop the Management Standards within an organisation.

The Management Standards emphasise the importance of that preventative approach, including the need to manage and improve the working environment. This is done through a five-step process as shown in Figure 2.

Figure 2: The HSE Management Standards Intervention Cycle



This approach also involves a preparation stage, which involves securing commitment across the organisation, identifying intervention champions, forming a steering group to oversee the process, and developing an appropriate communication strategy. Then, as Figure 2 shows, supporting mental health and wellbeing is a continuous and iterative process. The HSE Management Standards provide the framework in which to identify potential risk factors before appropriate changes are made to the working environment.

2.2.2. Mental Health at Work Commitment

The Mental Health at Work Commitment[38], from the mental health charity MIND, consists of six standards (Box 1). These are based on the Thriving at Work review and draw on existing pledges and standards and the relevant research evidence.

This framework supports organisations – both small and large - in promoting mental health and wellbeing. Crucially, the first two standards in Box 1 emphasise the importance of not only taking that systematic and holistic perspective, but that there is a need to manage positive mental health outcomes by proactively managing work design and organisational culture.

To meet the six standards the Commitment is underpinned by 21 supporting actions, alongside guidance for implementation and signposting to useful resources. In addition, the CIPD also offers a repository of resources that organisations can use to meet the six standards.

Box 1: The Six Mental Health at Work Commitments

1. Prioritise mental health in the workplace by developing and delivering a systematic programme of activity
2. Proactively ensure work design and organisational culture drive positive mental health outcomes
3. Promote an open culture around mental health
4. Increase organisational confidence and capability
5. Provide mental health tools and support
6. Increase transparency and accountability through internal and external reporting

2.2.3. ISO 45003

ISO 45003 is a global standard giving practical guidance on managing psychological health in the workplace[18]. They support organisations to better promote wellbeing at work and to prevent work-related injury and ill-health. It is based on ISO 45001, the internationally recognised standard for occupational health and safety management systems[39].

Applicable to organisations of all sizes and sectors, ISO 45003 uses a risk management approach to identify, assess, and control psychological hazards and risk in the workplaces. Similar to the HSE Management Standards and the Mental Health at Work Commitment, the aim here is to support organisations to take a proactive, systematic, and preventative approach to managing worker wellbeing.

The Standards draw on the importance of effective leadership and worker participation, and uses a staged approach to:

1. Understand the context of the organisation;
2. Assess the psychological risks that need identification;
3. Determine the resources and support needed within the organisation;
4. Develop appropriate actions to address the hazards identified;
5. Monitor, measure, and analyse for any changes;
6. Continuously improve by learning from the process and adjusting accordingly.

The flexibility within the Standards allows it to recognise all psychosocial factors that can affect workers, including home working, workload management, organisational culture, and violence.

2.2.4 Develop a bespoke approach

These are some of the systematic approaches and standards that organisations can implement to improve mental health and wellbeing. However, for some organisations it can be beneficial to take the best elements from these and use them to develop a bespoke model or diagnostic tool for the business that aligns better with the organisation's strategies, culture and values.

3. THE ROLE OF OCCUPATIONAL HEALTH AND HUMAN RESOURCES ACROSS THE INTERVENTION LEVELS

OH and HR practitioners have different areas of responsibility. For OH, their primary emphasis lies in the protection and promotion of workers' physical and mental health. This draws on OH as a branch of medicine concerned with relationship between work and health, providing advice and support to both workers and organisations[7, 35].

The availability of OH support varies substantially across organisations and industries. About half of organisations have OH access, with large organisations five times more likely to have in-house support available[41]. For many organisations, OH support might be commissioned from external services or even be non-existent. In terms of roles, OH practitioners can come from a diverse set of backgrounds, including physicians, nurses, therapists, hygienists, psychologists, and ergonomists.

For HR, the primary emphasis is in managing an organisation's workforce, from recruitment to exit, that can fulfil the needs and functions of the organisations[35,42]. For many organisations, responsibility for mental health and wellbeing would sit with the HR function. This could be because there might be expertise situated within it, or that HR would facilitate access to the required expertise.

Despite these differences, OH and HR share a common goal of creating an inclusive and high performing workplace, where employee's health and wellbeing are valued, not just in terms of productivity and return on investment, but also in terms of how employees think and feel about their job and organisation[11]. It's about being a responsible employer.

Table 2 (next page) provides a brief overview of the contribution that OH and HR can offer at each intervention level. This is a general overview, and there can be substantial variation from organisation to organisation, and the exact set up of the HR and OH service.

What this shows is the value of OH to be more than just a referral service, and that HR is key when taking a proactive approach to manage staff wellbeing given its access to a lot of the levers that affect how an organisation is run. It's time to encourage stronger collaboration between the two professions to achieve a more strategic and preventative approach to employee health and wellbeing.

Box 2 and Box 3 each provide three case studies as examples of how OH and HR can respectively offer support across the three levels.

Box 2: OH case studies supporting worker health and wellbeing

- *A Ministry of Defence (MoD) Business Unit*

The organisation never had a coordinated wellbeing programme, and the case study captures the work and activities to develop one that revolved around three areas: to educate, measure, and connect.

More information available here.

- *The National Police Wellbeing Service (NPWS)*

The launch of the NPWS covers the merging of eight live services under one brand, including leadership and management, psychological screening, support during and after major incidents, development of peer support networks, resilience training, and wellbeing at work. The framework used by NPWS maps on the three intervention levels, and take the form of promotion, prevention, detection, support, and treatment and recovery.

More information available here.

- *The BBC*

The work here highlights a more holistic role for OH within the BBC to protect workers, promote health; advocate for communities within the workforce, and aid the management of employees with medical conditions and sickness absence.

More information available here.

Table 2: An overview of the different functions of Occupational Health and Human Resources at the primary, secondary, and tertiary level.

Intervention level	Occupational Health	Human Resources
Primary (Prevention) *Focused on identifying potential risks in the psychosocial work environment, with the aim to eliminate or reduce the identified risks at source*	Health screening; Identification of health issues and patterns; Compliance with regulations and policies; Inputting into organisational strategy.	Ensuring the organisation provides 'good' work' for people to support their health. Developing a health and wellbeing strategy; people management policies and procedures in areas such as reward and recognition, performance management; organisation design; job design. Administering and analysing staff surveys and focus groups; diversity and inclusion activities; Fostering healthy working relationships; encouraging voice and recognition schemes. Managing absence and attendance. Managing change.
Secondary (Support) *Aim to modify how a worker manages or responds to potentially harmful work environment factors, and to reverse or delay the progression of health problems caused by these factors*	Improve health and wellbeing awareness; Fit notes and work adjustment plans; Health promotion activities; Ergonomic assessments; Vaccinations and immunisations; Reasonable adjustments due to illness or disability.	Awareness raising and education; Training of managers and staff; Providing health promotion activities; Personal and professional development; Coaching; Wellness tools and resources (e.g., Digital mental wellness platforms); Performance reviews and goal setting.
Tertiary (Restoration) *Seek to reduce or minimise the negative health effects associated with chronic exposure to psychosocial risks, and to enable a return to normal functioning*	Treatment and rehabilitation; Review and referrals to more specialised support services (e.g., physiotherapy, psychological support); Support return-to-work programmes, individuals, and line managers.	Support return-to-work programmes, individuals, and line managers; Signposting to support services and rehabilitation services; Manage Employee Assistance Programmes.

3.1.1. OH and HR at the primary (prevention) level

At the primary level, OH plays an important role in the identification of potential workplace risks and hazards, and in monitoring occurrences of ill-health and injuries. A systematic screening and assessment of information will help identify areas of concern and highlight priorities for action. For example, the MoD business unit case study highlights the use of a workplace wellbeing diagnostic tool to identify areas where issues laid, and to create a benchmark from which progress can be measured. The focus in the NPWS case study to identify and address stressors, and to improve organisational climate and culture are also examples of OH working to create healthier working environments.

OH's understanding of occupational health will also ensure compliance with corresponding health and safety legislation, policies, and guidance. This is evident in the BBC case study, where OH work together with union representatives to ensure appropriate safety and risk mitigating measures are in place that meet the relevant legislation. If done right, all this will contribute to a safer and healthier working environment where workers are likely to experience better mental health and wellbeing[43,44].

Box 3: HR case studies supporting worker health and wellbeing

- *Leek United Building Society*

HR had a peripheral role until the appointment of a new CEO. A stronger focus on health and wellbeing was made after HR was included on the executive committee, and an extensive consultation strategy that resulted in a new Employee Support Programme that was built on (i) line manager support, (ii) executive promotion, (iii) third-party support, (iv) in-house support, and (v) pandemic-specific support and communication.

More information available here.

- *Scottish Council for Voluntary Organisations (SCVO)*

This case study covers the work done to address the toxic culture within the organisation and to build a coaching culture to empower staff. This went alongside efforts to encourage an employee-centric, flexible approach to wellbeing, establish trust and encourage employee voice, and to promote role-modelling.

More information available here.

- *Barnwood Trust*

Using a people analytics approach, the organisation was able to collect better data from their new HR information system. This helped facilitate understanding of unequal pay rates across the organisation as well as areas where there was low uptake of annual leaves. Initiatives could then be targeted as addressing this imbalance and creating a better, and more fair, working experience for staff.

More information available here.

While the focus of this report is on mental health and wellbeing, research is clear that physical risks and hazards in the workplace are a potential source of distress for workers. This has been evident throughout the COVID-19 pandemic where there has been significant concern about exposure to the virus[44], which is also reflected in the BBC case study. This same concern can extend to other physical aspects as well, including concern about exposure to unsafe working environments, asbestos, dust, and loud noises. Here, OH has considerably expertise in screening and risk identification[45].

Although HR might not always have an explicit focus on mental health and wellbeing, their emphasis on developing and supporting the workforce relies on creating an environment that is conducive to the needs of the individual worker and the organisation. Having a culture where one is appreciated, where one can exert some control and have a say in things, and where there are healthy and supportive relationships are all key factors that lead to a positive working environment. This is evident in the Leek United Case Study, where over 50 separate workshops and multiple pulse surveys were carried out to inform the people strategy.

This means developing policies and procedures that are clear and fair, and that appropriately manage potential sources of distress for workers, including workload, remuneration, conflict, and work-life balance. We see this in the SCVO case study, where key policies were reviewed and updated to ensure they supported the desired culture, including emphasising a blended working policy. This included changing the language of communications from the passive to the active voice, making it clear who was making decisions to improve accountability and trust.

The example from the Barnwood Trust showcases how data can be used to identify the discrepancies in worker experience and why that might be. This in turn resulted in a new job evaluation framework with a more equal pay scheme. The digitalisation of information services also then offered the option for more flexible working for workers.

Most of the case studies emphasise that OH and HR should lead at the organisational level when developing organisational policies and strategies where workforce mental health and wellbeing is a key aim. With Leek United changes only began when HR was included on the executive committee, while OH was pivotal in raising awareness among leaders in a MoD unit, manage ill-health at across the entire BBC, and pushing for organisational changes across UK police forces.

3.1.2. OH and HR at the secondary (support) level

OH can support worker mental health and wellbeing through a range of secondary-level interventions. A key aspect here is in increasing health and wellbeing education and awareness which can target both physical (e.g., smoking cessation, diet) and mental (e.g., managing and identifying symptoms) health. For example, the BBC case study highlights the work done to raise awareness about COVID-19 protection in the workplace, and the development of podcasts and learning materials around promoting healthy lifestyles.

At the individual level, OH practitioners might work with individuals to identify their risk level, and to take appropriate mitigating actions to prevent or reduce the likelihood of developing ill-health. Within the NWPS case study there was psychological screening, peer support, and resilience training as activities to better support police officers. This can also exist at the group level, where OH practitioners might support managers to recognise and address signs of stress or mental health concerns in their teams.

OH also work with workers, line managers, and HR to review, support, and implement the necessary changes where a worker has a fit note or where adjustments are required due to an illness or a disability. The BBC case study shows this, where supporting COVID-related absence and return is also covered.

HR practitioners may be able take on similar tasks as OH practitioners here, especially in terms of raising awareness and providing education around mental health and wellbeing. Where expertise exists locally, HR practitioners might deliver similar training themselves. Otherwise, HR will often facilitate access to such programmes by working with OH or other relevant experts. This can also be in the form of different resources that range from written literature to self-guided training content, or digital tools such as apps and online platforms. Examples are seen at the SCVO who have a Teams channel to share articles and classes related to mental health and wellbeing. Similarly, Leek United augmented internal resources together, making information (e.g., health eating, domestic abuse champions, mental health first aiders) more accessible.

Mental health and wellbeing can also be supported though other generalist HR activities, such as coaching, performance reviews and goal setting, and personal and professional development. What these offer is a space and opportunity to reflect on their own needs, and to develop appropriate actions at both the individual and organisational level to support the worker to achieve that. For example, in the SCVO case study coaching helped transform employee experience, encouraging changes to work practices that benefited many. Similarly, the line manager training offered by Leek United was important to develop managers that were better able to support the needs of their team members.

3.1.3. OH and HR at the tertiary (restoration) level

OH at the tertiary level can be instrumental in support pathways and the delivery of the treatment and rehabilitation of workers struggling with their mental health and wellbeing. In the NWPS case study, the OH service provides support for individuals with complex needs, including those who have experienced significant trauma and distress through their roles. The NWPS and the BBC case studies both show how OH services can also facilitate access to appropriate medical professionals, coordinate rehabilitation programs, and provide guidance on workplace adjustments or accommodations to support employees' return to work after illness or injury.

Almost 95% of fit notes are signed as 'not fit' without suggesting any adjustments or advice that could help keep patients working when living through a period of ill health. This is as fit notes are often poorly understood by GPs and therefore be an inaccurate reflection of an individual's ability to work[46]. Therefore, the role of OH in supporting return to work can be particularly important when understanding why an individual has gone of sick with to begin with, and whether information needs to be passed back to the organisation to address possible underlying issues.

HR may not be able to provide treatment, but they would typically be responsible for managing Employee Assistance Programme such as in Leek United's digital mental health support platform which is monitored by professionally trained clinicians. While none of the case studies provided examples, HR also have an important role in supporting individuals and their line managers within the return-to-work process[47].

3.1.4. The overlap between OH and HR

Table 2 and the sections above are not intended to be definitive comparison of what OH and HR offer. There will be a sliding scale from one end to the other, such as where in some organisations OH are involved in setting organisational strategy. Similarly, in some settings HR have the expertise to deliver training and content on health promotion activities themselves or carry out risk assessments within their workplaces. However, it is vital that one is aware of the limits of one's competence and to not practice in an area where one is unqualified in.

Even within the professional groups there can be substantial variation. Within OH, some professionals work internally and others provide external services based on very narrow contracts. The levels of expertise can also differ, such as between an OH physician and nurse, or between an individual's specialisation (e.g., mental health, musculoskeletal disorders). The same is evident within the HR profession, where the CIPD outlines the different competencies and activities related to wellbeing based on four different membership levels (i.e., Foundation, Associate, Chartered Member, Chartered Fellow)[48]. For example, at the Foundation level one is expected to "*understand what data is effective to identify and monitor wellbeing trends*", while Chartered Fellows are expected to "*use wellbeing data and information to inform and continuously drive business strategy*".

It is equally important to note that some of the duties and roles outlined above can fall under the responsibility of other functions within an organisation, including health and safety, learning and development, management development, or human factors. Regardless, what this shows is most importantly, the need to recognise the limitations of one's qualification, knowledge, abilities, and experience.

3.2. Developing synergy between OH and HR

It is evident that HR and OH functions working together can create a strong influence on managing the organisational practice[11]. The ability to be able to assess and manage employee attitudes to their work, especially around perceptions of risks and compliance with health and safety legislation, can be better achieved through their collective wealth of expert advice and guidance. This collaboration can take the form of:

- Developing strategy, initiatives, and guidance together. This should take an employee-centred perspective to consider any impact of the employee's mental health and wellbeing.
- Carrying out an audit of OH and HR functions, skills, and competence to identify strengths that can be harnessed, opportunities for cross-collaboration, and gaps to be developed within the organisation. This includes available data collection and surveillance methods and technology, including how this is accessed and used.
- Fostering more open communication between both OH and HR and a better understanding of each other's expertise and remit. This would facilitate sharing of research and good practice from each respective fields, and on the available data to better understand current and future risks within the organisation.
- Identifying key stakeholder groups and individuals within the organisation, and how OH and HR can build relationships with them.
- Coordinating training and awareness programmes.
- Championing the strengths of OH and HR.
- Continually learning and improving by evaluating the effectiveness of the work carried out and implementing any learnings from the process.
- Work out barriers that prevent efficient collaboration between HR and OH (e.g., use of jargonistic language, budgetary restrictions, different timelines, unclear processes, recommendations or requests, confidentiality).

CIPD research[10] of HR suggests that many employers, and HR professionals, tend to view OH as a resource for referral, to deal with complex cases of sickness absence when ill health issues have already escalated. But there can be clear benefits from involving OH in health-related issues at a strategic and practical level at an earlier stage. Ultimately, developing a strong partnership will enable organisations to develop a more focused and strategic approach to preventing ill health where possible and optimising employee wellbeing.

3.3. Champion the value of OH and HR

The sections above champion the value and the role that both OH and HR play in supporting the health and wellbeing of workers. The challenge lies in what to do when there is lack of availability of the other service to either OH or HR, or when there is lack of suitable expertise within either OH or HR.

Championing OH

- The Society of Occupational Medicine's Value Proposition[7] summarises the business case for investment in occupational health services based on wide-ranging and sometimes intangible factors, and can be helpful in creating a business case for more OH support. The guides on how to commission an OH services[45,49] are a useful resource.
- Review what OH services or EAP provision are already in place and how this can be expanded upon to take a more holistic perspective. For example, how might data about EAP cases be taken into account when making organisational decisions and planning?
- Confidentiality may restrict OH's ability to feedback the specifics of an individual's case. However, it may be possible to summarise common themes and issues at a group level. With the use of the right software and access control, OH teams can get the data they need without having to risk patient confidentiality or impacting the privacy of employee's health records.
- Utilise the government's OH subsidy pilot to support SMEs in England, which include incentivising greater take-up of Occupational Health provision through the tax system.
- Engage with professional bodies like the Society of Occupational Medicine, Faculty of Occupational Medicine, Faculty of Occupational Health Nursing or the British Occupational Hygiene Society to develop a better understanding of what OH resources and services might be available.

Championing HR

- Challenge the organisation's strategy and purpose, and how the workforce features within this. This provides a starting point to explore how workers are managed, supported, and developed.
- Assess the health needs of the workforce and map wellbeing provision and policies to ensure they support people with their health needs and through the employee lifecycle and with challenging life events.
- Review current HR offerings against the activities in Table 2 to identify potential gaps that could be addressed.
- Review how data about health issues and screenings are being collected and managed. To consider whether there is scope to identify different software, technology, or processes to better facilitate this process.
- The CIPD offers resources, including on how to make maximum impact as an HR professional in an SME[42], that can be useful in building up internal HR capacity and resources.
- Encourage involvement in the CIPD, where an initial Foundation membership can be developed into higher levels, with a greater impact on the organisation.

4. WHAT CAN AN ORGANISATION DO?

The previous sections demonstrate the need for organisations to take a more systemic and proactive approach to support worker mental health and wellbeing, and the contributing role of Occupational Health and Human Resources with this.

To further support organisations aiming to improve staff wellbeing, this section is structured according to seven questions that can be used to guide the intervention process. These are broadly based along the Plan – Do – Check – Act process that underpins most intervention frameworks[36, 37, 50], recognising the importance of an appropriate risk assessment, using evidence to inform decision making, and evaluating the process that has underpinning.

Although the seven questions suggest that these might be seven distinct and separate steps, in practice this would be an iterative and continuous process where the response to one will continue to impact on the other.

The seven questions are:

1. What are we looking to achieve?
2. What are the factors that contributed to this?
3. Can we address these underlying factors?
4. Can we better support our workers with what they do?
5. What is the evidence for the interventions being offered?
6. Who has the expertise to support us with this?
7. How do we know this has or will work?

These questions are expanded in more detail in the section below, and where possible covering the role of OH and HR, as well as drawing on some of the case studies from Box 2 and Box 3.

4.1. What are we looking to achieve?

To begin with be clear on what the problem or the goal is that the organisation wants to work on. Is there a desire to improve job satisfaction scores? How can stronger mental health and wellbeing be developed and fostered in the organisation? Are there concerns around sickness absence or turnover rates? The latter was the case in the NPWS case study where the service was developed to better support staff welfare in the police. Alternatively, there may be concerns raised about mental health and wellbeing in feedback sessions or staff surveys – as was the case in the SCVO example which attempted to address a toxic culture.

Establishing what the organisation wants to focus on can help determine what needs to be done, particularly around assessing the working environment, and identifying any potential underlying risks and contributing factors towards the intended outcome. It also offers the opportunity for HR, OH, and other related functions to scope out their responsibilities to work out how they can best contribute to the upcoming intervention.

4.2. What are the factors that contribute to this?

Research and legislation highlight the importance of identifying what the underlying risk or promoting factors are within the organisation that is contributing to the organisation's goal. Here, an evidence-based framework (e.g., the HSE Management Standards, ISO 45003) can be useful. The primary purpose here is to conduct a risk assessment to gain a thorough understanding of the actual work environment. This also underpins the primary intervention approach which emphasises the importance of proactively managing the working environment, avoiding the temptation to do something that might not be relevant only because something needs to be done.

A list of measures conducive to carrying out a risk assessment are presented in Box 4 (next page), although other forms are also available. The main thing to consider is whether the data being collected is an accurate representation of what the risks might be that exist in the workplace. This data can also encompass other sources within the organisation. Some of this might be under the purview of HR (e.g., turnover rates, staff survey scores) while others might be within OH's remit (e.g., health screening, health records). Additional forms of data (e.g., spending, sickness absence rates) might be link back to HR or OH, or to a different organisational function altogether.

Having measures (and data) that are valid and accurate is important to inform evidence-based practice. The MoD Business Unit example describes how the Civil Service Survey lacked sufficient detail, leading to the use of a workplace wellbeing diagnostic tool developed by the What Works Centre for Wellbeing. This demonstrated that different sites and staff groups had profoundly different wellbeing experiences, leading to the conclusion that a 'one size fits all' strategy would probably be ineffective. Instead, there was a need to develop a light central structure which measures, monitors and advises, with evidence-informed action being delegated to local leadership and wellbeing networks.

This process could be different from one organisation to the next, including how they collect, store, process, and manage that data. The ability to link different data sources might also help identify new patterns and other areas of concerns that warrant addressing. The complexity of data management and analysis can vary substantially and could potentially link in with other developments in this area such as people analytics. Developments in digital platforms to facilitate health surveillance and data collection also offers the prospect of additional insights. The Barnwood Trust case study highlighted how their new HR information system paired with external salary benchmarks allowed them to show pay discrepancies within the organisation and against the market, as well as identifying groups which were not taking their annual leave. All of this gave them the data demonstrating potential inequality and the justification from which to make changes to improve on this.

4.3. Can we address these underlying factors?

Box 4: Surveys to facilitate risk assessments

HSE Management Standards Indicator Tool: Discussed in Section 2.2.1, this 35-item tool maps against the six domains of the HSE Management Standards – demands, control, support, relationships, change, and role.

HSE Stress Talking Toolkit: These toolkits are designed to help managers talk with workers as part of their overall approach to preventing and managing work-related stress. Originally developed for smaller organisations, they can also be used in larger organisations by line managers, senior managers, and HR at various points of the employee journey. A general toolkit exists alongside specific ones for construction, education, and healthcare settings.

What Works Centre for Wellbeing's Questionnaire Bank: A collection of validated items from various evidence-based sources to assess a wide range of wellbeing and workplace factors. This can then be tailored and adapted to local needs.

Business in the Community's Responsible Business Tracker: This is a broad assessment of the workplace based on BITC's Responsible Business Map which was built on the United Nation's Global Goals. One of the areas covered is Health and Wellbeing, where a key action is to take a preventative whole-person, whole-system approach to health and wellbeing that gives employers and employees collective responsibility.

Mind's Workplace Wellbeing Index: A benchmark of best policy and practice. It provides a comprehensive assessment to gain employee feedback on how to support their mental health, including analysis and reporting of results with recommendations on areas to improve.

Acknowledging the responsibility of the employer to create a safe and healthy workplace would require an organisation to eliminate or address any of the risks identified within their risk assessments[7]. This also fits in with the research evidence indicating that an approach that includes primary-level interventions are the most conducive[30,31,36].

Risks relating to mental health wellbeing typically revolve around psychosocial working conditions (Table 1). Within this, research has consistently shown that factors such as workload, manager support, peer support, emotional demands, work-life balance, time pressure, and lack of control are consistent predictors of poor mental health and wellbeing[22,23,51,52]. Equally, promoting control, role clarity, and support in the workplace can promote better mental health and wellbeing.

The actions required to manage these do not have to be explicitly mental health and wellbeing focused as they would usually require adaptation to how the workplace is organised, designed, and managed. For example, the SCVO case study showed that to provide more control to workers and to help support their desire to work flexibly, the organisation not only changed their policies to support but this but provided the resources to ensure workers had the appropriate equipment required to work from home safely.

Consequently, while some of these activities are under the direct control of HR and OH, it may be that part of their responsibility here is to educate and advocate for changes involving stakeholders from across the organisation. This may require a change of perspective as traditionally OH, HR, and line managers might work together to make reasonable adjustments for an individual worker who may be struggling; instead, what is happening here is the need to facilitate reasonable adjustments for the entire workforce.

Another challenge lies in determining what actions are appropriate. This is where the risk assessment, together with dialogue with workers and stakeholders, is essential to establish what the priorities are and what changes are needed to be made as this needs to fit the local context. We see this in a Wellcome-funded report summarising organisational-level interventions in the NHS, where across the 13 included case studies a range of different activities were taken to address the psychosocial risks identified within the case studies. A selection of these is presented in Table 3 (next page).

Table 3: Example activities from primary interventions to address identified psychosocial risks[36]

Psychosocial risk	Example activities undertaken
Workload	• Changed task assignments to avoid elective procedures overnight • Improved medication dispensing process • Reduced rota administration through team-based rostering • Reduced meeting times • Stopped collecting and discussing redundant data • Integrating training goals into the workday to avoid long training sessions
Work-life conflict	• Flexible rostering patterns • Advanced notice of rotas • Encouraging other forms of flexible work
Staffing levels	• Reallocating intervention savings to increase staffing • Developing apprenticeship programmes • Improving return-to-work process • Developing attendance policy • Reducing number of investigations or concluding them quicker
Conflict reduction	• Agreeing on common rules around shift requests • Sharing individual data with the group to demonstrate different work experiences • Training on building a restorative and just culture
Role clarity	• Developed written manuals, guidebooks, and FAQ documents • Team check-ins and huddles • Discussions to agree common standards for rostering and patient contact

4.4. Can we better support our workers with what they do?

Within a systematic approach to support worker mental health and wellbeing organisations must consider how to better support their workers. This means providing them with the knowledge, skills, resources, and abilities to manage their work tasks and environment - which would typically constitute activities at the secondary and tertiary level. Raising awareness, promoting health behaviours, and encouraging better coping and management strategies can be effective – but will also be limited in that they do not take that preventative approach.

This is also particularly important in settings where it is not possible to eliminate or substantially reduce certain psychosocial risks. For example, the nature of healthcare means that many workers here will be exposed to human suffering and distress, while those working in the hospitality may have to be available to work on night and weekend shifts. Ensuring that workers are best equipped to function in such environments would again form part an employer's responsibility.

Given the emphasis here is more on the individual, the role of HR and OH would be to identify those who may be at risk and to provide the necessary support and training. In the NPWS case study, OH's roles include administering bespoke psychological questionnaire and structure interviews to support the screening of individuals in high-risk roles, and to also support the delivery of the trauma risk management (TRiM) intervention after the occurrence of critical incidences.

4.5. What is the evidence for the interventions being offered?

Underpinning the process so far is the need for decisions and actions to support mental health and wellbeing in the workplace to be evidence based. This links back to the opening section of this report covering the different definition, measurement, and diagnosis related to mental health and wellbeing. It is important here to distinguish between interventions that claim to address subjective experiences of wellbeing (e.g., such as engagement, positive affect) against those which are used to support diagnosed clinical outcomes (e.g., common mental health disorders).

Similarly, interventions that can change someone's understanding and perception of mental health and wellbeing is important, but it is important to emphasise that changes in awareness and knowledge alone will very unlikely lead to behavioural change[53,54]. Crucially, it is not only about whether or not there is evidence, but the quality of the evidence and how consistent these findings might be[7]. Instead, the research evidence is clear that a systematic approach integrating primary, secondary, and tertiary level interventions which is underpinned by an appropriate risk assessment is likely to be the most effective approach[30, 31].

Amidst all the possible approaches it can be challenging to determine what the evidence underpinning that intervention is. Here, OH and HR offer can offer value by not only drawing on their respective subject matter expertise, but on their ability to seek out, synthesise, and make decisions with the evidence at hand. This encompasses the scientific literature contained within academic journals, although Box 5 (next page) lists several sources that provide high quality summaries of this knowledge made available to practitioners and the public.

OH and HR are also heavily involved in drawing on other forms of evidence[55] including internal organisational data and audit trails; the expertise and judgement of practitioners, managers, consultants and business leaders; and the input and concerns of other internal and external stakeholders.

This accounts for the specialised knowledge acquired through repeated experience of specialised activities that OH and HR have, as well as the internal and external networks that both functions have to engage with their stakeholders.

It is beyond the scope of this report to provide an overview of the evidence relevant to all mental health and wellbeing interventions. Instead, Appendix I provides a brief description of the research evidence of six popular wellbeing activities: health promotion; line manager training; mental health first aid; mindfulness training; physical activity and exercise; and resilience training. It also provides some contextual background and what this means for organisations.

What Appendix I shows is that for most of these activities there is some evidence that they can work in specific circumstances or for specific outcomes. Nearly all of them focus on the individual and do not take a preventative approach. So while there is evidence that mental health first aid can increase levels of awareness and reduce stigma[53, 56], this alone would not be congruent if the goal of the intervention was to reduce levels of sickness absence or to meet an organisation's regulatory responsibilities. Similarly, there is plenty of evidence supporting the effectiveness of line manager training, but only where this is set within an evidence-based framework, where the training is accompanied by further and ongoing support for line managers, and where the training extends beyond identifying team members who are struggling to also consider creating healthy working environments.

CIPD has carried out research with IOSH, HSE and Affinity Health at Work to review all the evidence available about what affects the success of developing managers who support employee engagement and wellbeing. These resources build on earlier work conducted in 2014 and are grounded in research which looked at both academic and practitioner literature. Practitioners can use the practical resources based on this evidence to develop management development programme that support employee engagement and wellbeing.

Box 4: Sources of evidence

The CIPD's evidence reviews

This repository contains different evidence reviews (e.g., rapid evidence assessments, critically appraised topics, literature reviews) summarising different topics related to the HR profession, including bullying and incivility, flexible work, and employee resilience).

What Works Centre for Wellbeing's Workplace Wellbeing Topic Resources

A collection of resources that provides an overview on several workplace topics related to wellbeing, including job quality, retirement, team quality, and job security.

Affinity Health at Work's Health Hub

The hub collates practitioner and academic evidence on evidence and resources on topics such as mental health awareness, obesity, neurodiversity, mindfulness, and stress.

The European Agency for Safety and Health at Work's OSHWiki Project

The free Occupational Safety and Health encyclopaedia contains numerous wiki-style articles written by subject matter experts on various occupational safety and health topics.

SOM Value Proposition Report

This report provides a brief but critical review on several health interventions including physical activity, dietary interventions, multi-component workplace interventions, smoking cessation, and mental health interventions.

4.6. Who has the expertise to support us with this?

Given that evidence around supporting worker wellbeing can be very contextual, it is important that the work being carried out is done by appropriately qualified people. This can help ensure that interventions are grounded in good practice and the relevant scientific evidence base, and that there is protection to the workers and the organisation.

However, the reality is that there is very little oversight and regulation in the mental health and wellbeing space. Despite this, it may be helpful to check whether individuals or groups working on the intervention are registered with:

- A relevant ***regulator*** such as the General Medical Council (e.g., physicians), the Nursing and Midwifery Council, or the Health and Care Professions Council (e.g., occupational therapists, practitioner psychologists).
- A relevant ***professional body*** (e.g., Faculty of Occupational Medicine, Society of Occupational Medicine, British Occupational Hygiene Society, British Psychological Society, Chartered Institute of Personnel and Development, Faculty of Occupational Health Nursing, Royal College of Nursing).

What the above provide is a level of assurance that their members or registered individuals hold the necessary qualifications and expertise related to their field. This typically involves being able to draw on the best available evidence and demonstrating professional competence in this field. In some instances, relevant qualifications and training from the appropriate accrediting or professional body also be appropriate.

Some of the above are directly related to certain aspects of mental health and wellbeing (e.g., occupational medicine) while others may have expertise in a related field that does overlap with this area. For example, an occupational hygienist might be familiar with health and safety legislation or safety standards that could apply to adoption of the ISO 45003 standards for mental health in the workplace. In contrast, a general practitioner may be registered with the General Medical Council but may not have the additional training in the field of occupational medicine. Similarly, a Clinical Psychologist may be a specialist in mental health but not in the workplace, or where a Fellow with the CIPD may be an expert in human resources but not in managing mental health. Nevertheless, the professional standards in which members are held to should mean that they are more likely to recognise the limits of their practice, and where they may have to draw on the expertise and qualifications of others.

The importance of qualifications extends to those delivering training and content as well, such as where a HCPC-registered dietician would be well placed to speak about healthy eating. Similarly, coaching has emerged as a popular programme for staff support. While there are coaching accreditation bodies (e.g., International Coach Federation, Association for Coaching, the European Mentoring & Coaching Council), there are also many unqualified individuals offering coaching without the relevant training[57].

4.7. How do we know this has or will work?

Fundamental to all interventions is the need to evaluate to see whether it made any difference and to consider any learnings from it. In practice evaluation can at times be difficult, but some evaluation is better than no evaluation, and organisations should continually strive to collect better data than before.

Evaluation should take two forms[58]:

- **Outcome evaluation** – did the intervention lead to any changes?
- **Process evaluation** – what happened during the intervention that might have affected the outcome?

4.7.1. Outcome evaluation

To put it simply, outcome evaluation focuses on whether the intervention had any effect. Within an organisation there could potentially be a wealth of data available, but it is important to consider what type it is and what that information would tell us. Table 4 structures different data across four different levels in terms of changes to workers' reactions, knowledge, behaviours, and results[59].

To create healthier working environments, interventions need to lead to changes at the behaviour and results level. This links closely with the initial data used to determine the issue and the potential root causes. What changes have been observed in relation to them? Organisations should link back to the original issues that brought about the need for these interventions; if the concern was high-levels of sickness absence or turnover – have these gone down?

As the organisation has a legal responsibility for the health and wellbeing of their workforce it is also important to reflect on whether this responsibility is being met.

Table 4: The four levels of evaluation

Level	Aim	Example data
Reaction	Do workers find the intervention to be relevant and useful?	Surveys, employee feedback, and anecdotal evidence immediately or shortly after intervention or training.
Learning	Have workers acquired new knowledge, skills, attitudes, understanding, and/or confidence?	Surveys or tests to assess these aspects after the intervention or training, ideally comparing with scores before the intervention. Focus groups, interviews, discussions, anecdotal feedback where workers share what (and how much) they may have learnt).
Behaviour	Have workers changed their behaviours and/ or been able to apply their learning in their working environment?	Surveys where workers report changes in behaviours in themselves or in others. Observation or case studies in the workplace to assess changes in behaviours. Focus groups, interviews, discussions, anecdotal feedback where workers describe what behaviours have changed and why, including how this happened.
Results	Have the targeted outcomes from the intervention aims been met?	Organisational metrics such as sickness absence and turnover rates, staff survey scores, productivity, complaints, and return-on-investment.

4.7.2. Process evaluation

Process evaluation looks to understand the contextual factors and the process of running an intervention. Ultimately, this also helps to provide a better understanding about what actually worked, for whom, and under what circumstances.

Process evaluation allows the intervention to be adjusted and improved as it runs. This could include changing a communication strategy, advocating for additional resources, changing the structure and delivery of an intervention to better suit the workforce.

Perhaps a particular intervention that could be useful is being offered. However, due to its location or timing not being suitable, or workers not being given to engage during work time, the uptake and effectiveness of the intervention is being undermined (Figure 3). This is also seen in a job crafting intervention study[60], which showed no changes on mental wellbeing scores for NHS therapists before and after the intervention. But as the intervention took place at the start of the COVID-19 pandemic and a control group reported a decline in their mental wellbeing, this suggested that the job crafting intervention might still have had a beneficial effect despite there being no change in participants' scores.

Questions that might be asked related to process evaluation include[61]:

- Who took part in the intervention, and who did not? Why?
- What was the quality of delivery of the intervention?
- Were the key stakeholders supportive of the intervention?
- What were factors that helped make the intervention successful?
- What were barriers that hindered the intervention?
- How did workers perceive the intervention?
- How supportive were managers in this process?

Answering these questions requires a range of data sources that extend beyond that is used in outcome evaluation. These can include data related to questions above such as attendance and participation rates, interviews and focus groups, meeting minutes, organisational communication, and correspondence.

When measuring the effectiveness of a wellbeing strategy, the best approach is not to measure specific data sets in isolation and try to assume causality. For example, coming to the conclusion that because we have done some manager training on wellbeing, the sickness rates have reduced. Instead, it is better to pull together a range of data, both qualitative and quantitative, from different sources (such as HR, OH, EAP, MHFA), staff surveys and focus groups to form a holistic picture of how people are feeling and performing at work. It is then possible to identify areas where the organisation has strengths and also room to improve (based on the chosen model/ diagnostic tool). Repeating this process once a strategy (not a single intervention) has been delivered will then help to demonstrate the impact and return on investment in the strategy.

Figure 3: Comic strip highlighting intervention failure (from the Care Under Pressure Project[40])



5. CONCLUSION

It is encouraging that organisations have been investing into mental health and wellbeing, and that there is significant activity revolving around awareness raising. However, it is important to recognise that this alone is insufficient, and that both the law and research highlights the need to implement a systematic approach in relation to mental health and wellbeing in the workplace.

Workplace interventions should form part of an organisational framework and operate across the primary (prevention), secondary (support), and tertiary (restoration) levels. This should involve a risk assessment process that focuses on addressing psychosocial risks in the workplace, accompanied by secondary level interventions supporting workers within their roles and tertiary interventions supporting the rehabilitation of workers.

The need for this systematic approach is grounded in the organisation's legal responsibility as an employer. But organisations also have compelling moral and financial reasons to act[7]; there is not only a danger of losing employee trust, retention, and performance, but a risk of wasting limited resources on unproven wellbeing activities. Not getting this right can directly, and negatively, impact on the mental health and wellbeing of their workforce.

Crucially, the law defines the need for having competent persons within the organisation to take responsibility for mental health. This raises questions about who holds that responsibility. Certain aspects of mental health, especially around fitness to work and diagnosed mental health conditions fall under the responsibility of OH. However, the broader definition of mental wellbeing means there are aspects of wellness that is not seen from a medical angle. This may increase the likelihood of functions like HR misunderstanding their competence or making full or best use of the valuable specialism offered by OH. For their part, functions that do have the medical expertise like OH may not have an opportunity to be involved. As this report shows, both HR and OH have considerable expertise within their own professional parameters; when able to work together, their collaboration can make a significant contribution to supporting the mental health and wellbeing of workers.

The report provides seven questions to guide practitioners working in mental health and wellbeing on how to approach this topic, with some additional examples and guidance provided. These not only reinforce the need for a prevention-focused approach, but the challenges in drawing on appropriate evidence and in evaluating the interventions carried out.

As the focus around mental health and wellbeing in the workplace continues to grow, so does the corresponding wellbeing industry. Particularly with the growth in health related technologies, there is substantial variation in quality of content. On one hand there are gadgets, software, and applications that are well grounded in the principles of this report with corresponding evidence for efficacy that can be tailored to the relevant organisational context. On the other, employers might be tempted by such offerings accompanied by sleek marketing and designs that in practice have little evidence for their utility. Equally, the rapidly evolving world of work presents new risks, challenges, and issues for workers' health that OH and HR practitioners may struggle to keep up with. With this in mind, several recommendations are set out below.

HR and OH practitioners should:

- Adopt a systematic approach to managing mental health and wellbeing in the workplace, based on ill health prevention and managing the main risks to workers' health. This means recognising that 'good work' is good for health, and that organisational decisions, processes, activities, and policies impact on the working experience of individuals, and in turn their mental health and wellbeing.
- Develop effective working relationships, with mutual trust and credibility at its core. There also needs to be a clear understanding of where the respective roles and responsibilities of HR and OH for health and wellbeing stop and start, as well as other groups in the organisation, particularly leaders and managers.
- Recognise the boundaries of their competence in relation to mental health and wellbeing, and to work to increase the resource available to manage workforce mental health and wellbeing. This could be in the form of personal development, improving capacity within the organisation, or developing appropriate external support. As part of this, to not only recognise the value of OH but to support and champion access to this service within their organisations.
- Increase the influence within their work practices, to advocate and encourage their potential to input into mental health and wellbeing strategy and initiatives across the primary, secondary, and tertiary level.

Stakeholders across all areas should:

- Build the evidence base for effective interventions by making scientific data and knowledge related to mental health and wellbeing more accessible and understandable.
- Develop and share examples showing how HR and OH can work together. These should be reflective of the different organisational contexts (e.g., SMEs, where OH is an external provider or does not exist).
- Collate and share examples of good practice mental health and wellbeing interventions, especially around the risk assessment, actions taken, and evaluation process.
- More coordination across different stakeholders (e.g., policymakers, professional organisations, organisations) to promote learning and collaboration.
- Provide more accredited courses and training around managing and supporting mental health and wellbeing in the workplace.
- Consider the need for elements of self-regulation (e.g., common standards, certification) that may help indicate credibility.
- Be aware of the appeal of providers within the wellbeing industry, and continue to challenge them by questioning not only the corresponding evidence base but its relevance to the local organisational context.

APPENDIX 1

Overview of evidence relating to common mental health and wellbeing-related interventions in the workplace

Intervention	Definition	General research overview	Things to consider	Implications
Health Promotion Activities	These encompass a range of programmes based around education, training, and behaviour change with the aim to improve awareness and encourage better health behaviours. While these can target a range of health factors, these typically focus on diet, exercise, smoking, alcohol intake, mental health self-care, and musculoskeletal disorders[62, 63].	The evidence linking health behaviours (e.g., smoking, diet, exercise) to health outcomes are well established[64]. The question that remains is whether health promotion activities in the workplace can change the health behaviours of workers. One review of 23 different reviews various workplace health promotion activities found that there was strong evidence for favourable effects of workplace interventions, especially for interventions targeting physical activity and/or diet. There was also strong evidence for a positive, small effect on the prevention of mental health disorders and musculoskeletal disorders. In a review of 182,880 adults from 16 trials, health screening (e.g., cholesterol, blood pressure) was not linked with reduced morbidity or mortality, and neither overall nor for cardiovascular or cancer causes[65]. However, separate reviews have shown health screenings to be beneficial in reducing the risk of diabetes and cardiovascular disease[66]. There is some inconsistency with these findings, as not all reviews have observed similar beneficial effects of health promotion activities[62], or where beneficial impacts are only seen in workers who are already at risk for unhealthy behaviour, obesity, or other health problems were found to be more effective than where a program is delivered to all workers within an organisation[67].	Health promotion activities have been criticised for often not taking a broader perspective that recognises the wider context (e.g., the working environment)[62]. There is strong evidence linking the working environment to actual health behaviours[68–70]. For example, in a review[63] involving 11 European studies of 118,701 participants, found that those who reported high demands and low control at work were 1.25 times more likely to have all four unhealthy lifestyle factors (i.e., smoking, body mass index, alcohol intake, physical exercise). A more targeted approach to support workers at risk is more likely to lead to beneficial outcomes[62, 67], emphasising the importance of relevant health screening to identify the most salient health issues and the groups of workers most at risk.	Organisations have to recognise that health promotion activities can take many different forms. A more systematic approach where health promotion activities recognise and consider workplace factors are more likely to be successful. This reinforces the need for primary-level intervention activities, and where health promotion activities move beyond raising awareness to also support and encourage behavioural change.

Intervention	Definition	General research overview	Things to consider	Implications
Line Manager Training	Training here can cover a range of topics. These include general content around mental health and stigma at work; developing managers on specific skills (e.g., having difficult conversations); training on work design and risk assessments; and more specific topic such as managing the return-to-work process. The quality of the content within this training can vary substantially. For example, the line manager competencies for managing work-related stress[71] and employee engagement[72] is built on a strong evidence based in partnership with the HSE and CIPD.	A synthesis of data from 10 studies found that line manager training was effective at improving managers' mental health knowledge, non-stigmatising attitudes towards mental health, and improving behaviour in supporting employees. No effects were found in relation to psychological symptoms in workers[73]. CIPD has carried out research with IOSH, HSE and Affinity Health at Work to review all the evidence available about what affects the success of developing managers who support employee engagement and wellbeing[74]. These resources build on earlier work conducted in 2014 and are grounded in research which looked at both academic and practitioner literature. Practitioners can use the practical resources based on this evidence to develop management development programme that support employee engagement and wellbeing.	Training content makes a big difference on the working experience of workers. Where training moves beyond general mental health awareness (cf. mental health first aid section below) to include content relating to work design, psychosocial risks, psychological safety, and developing interactional skills, managers are not only more likely to report better awareness but to be more likely to proactively manage and develop healthier working environments[71,75]. The provision of practical resources and tools, grounded in evidence (e.g., Wellness Action Plans developed by MIND[76]), are also more likely to be well received by line managers. Similarly, where line manager training is integrated with other support and functions within the organisation (e.g., human resources, occupational health, senior management) these are more likely to lead to beneficial outcomes such as return-to-work[77]. Equally, guidance and flexibility is needed where constraints and challenges lie within existing organisational structures and processes[54]. CIPD HR practitioner research[3] finds that under half (43%) of organisations have trained managers to support staff with mental ill health, compared with 51% in 2020. It's therefore not surprising, given this low level of investment in line management capability, that organisations think that 'a lack of line manager skills and confidence to support wellbeing' is considered the main challenge for health and wellbeing in the coming year.	Organisations must identify what the purpose of line manager training is – improving mental health awareness, changing behaviours, becoming better people managers, handling specific health issues or processes, or developing healthier working environment. The content, and the quality of that content, needs to then match the intended aims. What is also important is that training does not function to only add more responsibility onto line managers, but instead should be an opportunity to support and integrate them into the wider organisational system.

Intervention	Definition	General research overview	Things to consider	Implications
Mental Health First Aid (MHFA)	MHFA is an international training programme which trains individuals to recognise the signs and symptoms of mental health problems. This enables them to initiate appropriate responses, such as listening, advising and signposting to other supports and services[53].	A report for the HSE[56] found there is consistent evidence that MHFA training raises employees' awareness of mental ill-health conditions. However, they concluded that was no evidence that the introduction of MHFA training in workplaces has resulted in sustained actions in those trained, or that it has improved the wider management of mental ill-health. Similar findings have been found by the Institute of Employment Studies, who concluded that MHFA performs no better than many of the alternative approaches[78]. It is a positive outcome that MHFA training can increase participants awareness about mental health, reduce stigma, and increase support for those with mental health problems[79], with some evidence that this holds up to six months later[80]. However, there is still little understanding of how long this learning will be retained, and whether this leads to actual change in behaviours.	Concerns about MHFA have been raised where the increased awareness raised can lead to situations where the mental health first aider or the organisation is not able to support the individual, or that MHFA leads to over-medicalising and diagnoses of common human distress[81]. The focus of MHFA is predominately on identifying signs of struggle and to signpost individuals accordingly. These would likely constitute activities that fit in as secondary or tertiary level interventions. A lack of focus on work design and risk assessments then places the onus on the individual – not the organisation – to do something[53]. Clear guidance and boundary management is needed for MHFA First Aiders, as the role may potentially attract individuals who themselves might be vulnerable, who may overstep their role in supporting their peers, or where peers and the organisation wrongly presume MHFA can provide actual mental health support[53].	Organisations have to recognise that MHFA does not operate in the same way as physical first aid at work does. Instead, MHFA is an overly simplistic approach for organisations to implement, which has a weak evidence base for its effectiveness. The available evidence suggests a role for MHFA to raise awareness, but that it has to then form a small part of an organisation's wider strategy, alongside efforts to address risks in the workplace and adequate support for MHFA First Aiders and individuals who might be identified as struggling.

Intervention	Definition	General research overview	Things to consider	Implications
Mindfulness	Mindfulness intervention aim to improve an individual's mindfulness levels, which refers to a psychological state of "being attentive to and aware of what is taking place in the present"[82].However, given that one review found over 25 different forms of mindfulness-based interventions[83] and that are multiple different definitions of mindfulness[84], it is then difficult to determine if an intervention labelled as "mindfulness" actually refers to this or if it might actually be some other intervention repacked.	In general, there is strong evidence from reviews that mindfulness following an established protocol can have a beneficial impact in clinical samples and the general population on outcome measures such as symptoms of depression, anxiety, stress, insomnia, pain, and hypertension[85, 86]. Within the workplace setting the effects of mindfulness interventions are more likely to be smaller[83, 87], and more likely from studies rated as lower quality. The link to organisational-related outcomes, such as performance, job satisfaction, and absenteeism is also much more inconsistent[87].	It is important to note that there is also clear evidence demonstrating that mindfulness can lead to a deterioration of mental health[83]. For example, one review[88] of 83 studies found that 65% of the included studies reported at least one type of meditation adverse events, which included anxiety, depression, cognitive anomalies, and suicidal behaviours. There is also substantial variation in the structure of mindfulness interventions, with the strongest evidence for the formal eight-week programme[86]. Moreover, there is a lack of evidence demonstrating a long-term beneficial effect of these interventions[84, 87]. This is in part due to the lack of longitudinal studies, the difficulties in maintaining a mindfulness practice, and that mindfulness interventions do not address the underlying root causes of distress in the workplace.	The research evidence does indicate that a well-defined and designed mindfulness intervention could be beneficial to some employees. The onus would then be on the organisation that this provider is able to deliver this. However, it is important that organisations recognise that this would likely be a form of secondary intervention that would need to be embedded within a wider organisational support strategy. Such an intervention needs to be delivered by an appropriately qualified individual who can manage any potential adverse reactions that may result from it.

Intervention	Definition	General research overview	Things to consider	Implications
Physical Exercise and Activities	Broadly this refers to "a structured form of physical activity, with the specific objective of improving or maintaining physical health or fitness"[89], and covers all exercise and physical activity classes (e.g., Zumba, yoga) as well access to gym facilities or memberships.	The link that physical activity and exercise is very well established with clear physical and mental health benefits for individuals[90, 91]. These include, but are not limited to, better moods, lower levels of anxiety and depression, and reducing the likelihood of developing cardiovascular disease, type-2 diabetes, and obesity. Within the workplace, a review of five interventions covering walking, exercise, and yoga found that workers reported better psychological wellbeing than those who did nothing[92], supporting an earlier summary of over 38,231 participants showing that some workplace physical activity interventions can improve both health and important worksite outcomes[93]. The researchers do caution that this is not conclusive given the methodological failings within the study. In addition, it is likely exercise that is more tailored to an individual's need or that is multimodal is more likely to be effective[94]. Another review of eight studies found physical activity programmes at work did not reduce levels of sickness absence or improve organisational productivity[94]. This is consistent with other reviews[95,96] that report physical activity programmes having a mixed effect on outcomes such as job satisfaction, turnover, and presenteeism.	In addition to the concern around the methodological quality of studies testing the effectiveness of physical activity interventions, one critique is whether participants are representative of the wider workforce[94]. Workers who are healthy, are already physically active, and who have access to the activity or facilities provided are more likely to engage with the programme[93]. While this benefit is a positive, it highlights that those workers who are struggling with their health and wellbeing are far less likely to engage with such programmes[96]. Those with high workloads and demands, and who are struggling with their work-life balance are also less likely to be able to partake in these activities[96].	Organisations should be aware that while providing physical activities, exercise classes, and gym facilities or memberships can benefit some workers, this would likely be those who require it least. How the work environment is managed has an impact on the engagement with physical activities and exercise. Therefore, work has to be designed in a manner that allows those who are interested to be able to take part. Effort is also needed to attract a broader range of the workforce. Crucially, physical activities and exercise do not form part of preventive approach that organisations should take, do not support workers who are already struggling, and there is no clear evidence that it will affect organisational outcomes such as sickness absence, turnover, and performance.

Intervention	Definition	General research overview	Things to consider	Implications
Resilience Training	There are many definitions of resilience, although a common one is where its defined as "an employee's capacity to sustain and to bounce back from problems, conflicts, lack of success, or situations that imply an increase of responsibility"[97]. There have also been work to see resilience as not being at the individual level but instead within the organisation, where resilience would be the "ability of an organization to anticipate, prepare for, respond and adapt to incremental change and sudden disruptions in order to survive and prosper"[107]. The challenge is in resilience becoming a buzzword which means different things to different people. In some areas there have been a backlash against the term resilience[98], with work in this area being rebranded as developing "psychological flexibility" or something similar instead. With some interventions not defining what resilience is[99], this is problematic as it is then unclear what is being studied and compared.	An evidence review[100] for the CIPD concluded that there is strong evidence that resilience interventions have positive effects on psychological resilience. However, there was considerable variation on the effect sizes found, suggesting that there are numerous other factors that affect this (e.g., content, delivery, facilitation). Here, as in other reviews[101], it appears that resilience interventions based on cognitive-behavioural therapy or on developing psychological capital are more likely to be successful. Although a summary of effects from 269 intervention studies improvements are seen on a range of outcomes relating to action, biophysical, coping, emotion, resilience, symptoms, and wellbeing –the magnitude of changes were not likely to make any practical difference[102]. Similar systematic reviews of resilience interventions[99, 103] did report improvements on measures of resilience as well as mental health and subjective wellbeing measures[99] – although the risk of bias in the included studies was reported to be high and that no concrete conclusions could be drawn.	It is also important to emphasise that the evidence demonstrating the effectiveness of resilience interventions is very mixed and varied, making it difficult to determine what forms of resilience training might work best. Most of the measures looking at the effectiveness of resilience interventions measure aspects of resilience, mindfulness, self-awareness, and self-efficacy[100]. This means the link to worker mental health is not clear. There has also been a shift in resilience training being developed to not only to support stress or anxiety management, but to also develop capacity and improve performance in challenging circumstances[104]. This in turn has led to pushback from workers who not only feel the onus of responsibility is being placed on the individual but that resilience training is a method in which even more pressure and demands can be placed on individuals[98, 105].	The evidence here has focused almost exclusively at developing resilience at the individual level, which would make this a form of secondary intervention. This counters the good practice evidence outlined in this report, as well as the organisation's responsibility to take a preventative and proactive approach to adapt the environment. Given the substantial variety in how resilience training is defined and run, organisations have to be careful that the training offered is actually appropriate to the context, and that there is corresponding evidence for it. The shift to an organisational perspective of resilience moves away from focusing on the individual, and instead emphasises that change and support has to happen with the organisation and not the individual.

APPENDIX 2

The questions below provide an overview of the content in Section 4 and can be useful for guiding the engagement process when dealing with work-related mental health and wellbeing.

1. What are we looking to achieve?

1.1. What is the issue that we are trying to address?

1.2. What are we trying to improve upon?

1.3. Why is this the case?

1.4. Who is being affected?

1.5. What are we already doing in relation to this?

2. What are the factors that contributed to this?

2.1. Have we carried out a risk assessment on this? Do we need to carry one out?

2.2. How do we know that these are the contributing factors?

2.3. What data do we have to help us understand this (e.g., internally, externally)?

2.4. Whose voices are we hearing? Who is not being represented in this data?

2.5. Do we have the expertise to understand this data?

3. Can we address these underlying factors?

3.1. What changes can we make to address these underlying factors?

3.2. What resources do we need to make these changes?

3.3. Whose support do we need to make these changes?

3.4. Can we engage staff to determine what actions or changes are needed?

3.5. Are we meeting our legal responsibilities for duty of care?

4. Can we better support our workers with what they do?

4.1. What skills, knowledge, or competence do we need to build up in our workforce?

4.2. Is this being offered as part of a larger programme that is also addressing the underlying contributing factors?

4.3. Are there any groups of workers that are at particular risk?

5. What is the evidence for the interventions being offered?

5.1. How do we know that the activities being offered are evidence based?

5.2. What is the quality of this evidence?

5.3. How relevant is this evidence for our current context?

5.4. How do we synthesise the evidence available?

6. Who has the expertise to support us with this?

6.1. Do we have the relevant internal expertise to carry out the work above?

6.2. What is the expertise of external parties in relation to the work above?

6.3. How is expertise being determined (e.g., experience, professional qualification, academic qualification, regulator)?

6.4. Does this expertise match the domain, or the work being carried out?

7. How do we know this has or will work?

7.1. What evaluations are we carrying out?

7.2. At what levels is evaluation being carried out – reaction, learning, behaviour, or results (Table 4)?

7.3. How well to these evaluations align with the original aim of the intervention?

7.4. Over what time frame do we need to evaluate the intervention?

7.5. What are the contextual factors that helped or hindered the work being done?

7.6. What data do we have at hand? What data will be needed to collect?

7.7. How will our learning inform what we do next?

7.8. Who took part and who did not in the intervention? Why?

7.9. What was the quality of delivery of the intervention?

7.10. Were the key stakeholders supportive of the intervention?

7.11. How did workers perceive the intervention?

7.12. How supportive were managers in this process?

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