Mental Health Promotion Interventions and Supports Provided by Voluntary Organisations to Workplaces

Full Report

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Executive Summary

Introduction

Promoting positive mental health and supporting people with mental disorders in the workplace is associated with improved health and wellbeing, reduced absenteeism, increased productivity and improved financial returns (World Health Organization [WHO], 2000). Investing in the mental health of the workforce is increasingly being recognised as being good for workers and for business. Promoting workers' mental health and wellbeing leads to increased commitment and job satisfaction, improved productivity and performance, staff retention and reduced absenteeism (Health and Safety Executive, 2009; WHO & Burton, 2010; World Economic Forum, 2016). Mental health problems, such as depression and anxiety, are the leading cause of sickness absence and long-term work incapacity in most developed countries (Joyce et al., 2016). The effects of stress and mental health problems in the workplace have significant impacts at an individual, organisational and societal level (WHO & Burton, 2010). Mental health promotion in the workplace is a critical strategy in improving outcomes for both individual employees and the organisation as a whole.

A mental health promotion approach brings a clear focus on the mental health potential of people and is concerned with achieving positive mental health and wellbeing by strengthening protective factors for good mental health, enhancing supportive environments and enabling access to resources and life opportunities for individuals and communities that will promote their social and emotional wellbeing (Barry et al., 2019). Reviews of the evidence suggest that an effective workplace health improvement policy should include: promoting the mental health and wellbeing of all staff (promoting resources for positive mental health and reducing or eliminating stress), offering support and assistance to workers experiencing mental health problems in the workplace, and adopting a positive approach to employing and re-integrating workers with a history of mental health problems (Harvey et al., 2014). A strategic and coordinated approach to promoting employees' mental health is therefore required, including adopting a comprehensive organisation-wide approach, working in partnership with key stakeholders in integrating mental health in all workplace policies and practices concerning managing people, employment

rights, and working conditions (National Institute for Health and Care Excellence [NICE], 2009).

Policy at a national level is consistent with the approach advocated by the WHO. Ireland's *Sharing the Vision* mental health policy identifies workplaces as a key setting for progressing policy objectives, recognising a "core role" for the voluntary and community sector (Department of Health, 2020; p. 19). The National Healthy Workplace Framework (forthcoming), links with Ireland's overarching national health and wellbeing policy, *Healthy Ireland* (Department of Health, 2013). The framework is underpinned by a comprehensive consultation from which it emerged that mental health in the workplace is a priority issue. Participants emphasised the role the workplace can play in both the creation of positive mental health and also in facilitating recovery from mental ill-health (McAvoy et al., 2018). The approaches advocated in the National Healthy Workplace Framework and within *Sharing the Vision* are consistent with the approach taken in *Connecting for Life*, the National Strategy to Reduce Suicide (National Office for Suicide Prevention [NOSP], 2015), which recognises the need for a whole-of-government approach, working with a range of sectors and organisations, including workplaces and the community and voluntary sector.

Mental health voluntary organisations are an important resource for workplaces, providing expertise in awareness-raising and stigma-reduction and addressing specific mental health topics. As such, voluntary organisations have a critical role in progressing the actions identified in *Sharing the Vision*, and in being part of the whole-of-government approach advocated within *Connecting for Life*. Mental health organisations in the voluntary sector offer a variety of supports and interventions to address mental health issues in the workplace and there is currently a significant demand from employers for support with aspects of mental wellbeing. However, we do not have a comprehensive picture of the nature of supports and interventions that are being requested, offered or provided to workplaces by mental health voluntary organisations, and how these align with models of international best practice.

Research Aim and Objectives

The aim of this project is to map the range of mental health promotion supports and services that are offered by the voluntary sector to workplaces and to identify the most effective and feasible evidence-informed approaches that could be adopted to promote the mental health and wellbeing of workers in the Irish context.

Objectives of the study are:

1. To identify key mental health organisations in the voluntary sector who provide supports to workplaces.

2. To map the type and level of supports provided, including but not limited to: educational packages, workshops, training, advice, awareness events, strategy building, mental health literacy, structured programmes, and assistance in the evaluation of initiatives.

3. To undertake a rapid review of the international evidence with regard to models of good practice in the provision of mental health promotion initiatives in the workplace, in order to assist voluntary organisations to maintain a high level of evidence-informed practice.

Methods

The research entailed two separate studies: a rapid review of the international evidence and a mapping of existing practice in mental health voluntary organisations in Ireland. The methods, results and conclusions, identifying the who (target audience and programme implementers), what (programme components), where (setting) and how (implementation) interventions are delivered, for each study are presented respectively in Chapters 2 and 3. Chapter 4 draws on the synthesised findings from both studies to offer recommendations on how existing practices can be aligned with international evidence-based practice.

The rapid review of the international evidence included systematic reviews, meta-analyses and second-order reviews of the effectiveness of workplace mental health promotion interventions published in the last ten years (2010-2021). Selected academic databases (Scopus, PubMed, ASSIA, Cochrane Database of Systematic

Reviews) and public health and occupational health and safety websites were searched, resulting in 2770 articles, of which 43 reviews were included in the study.

The mapping study collected data from eighteen mental health voluntary organisations involved in the provision of support to workplaces. All voluntary organisations were invited to participate in both an electronic survey and in a virtual consultation. Of the eighteen participating organisations, seven submitted the electronic survey solely and a further five solely participated in a virtual consultation. Six organizations submitted both the electronic survey and participated in a virtual consultation. The total number of electronic survey responses included was thirteen and the total number of virtual consultations held was eleven. Analysis involved consolidating responses from the two data collection exercises.

Results

Rapid Review

The findings from the rapid review demonstrate that a wide range of interventions can be successfully implemented in workplaces to promote employee mental health and wellbeing, reduce mental health related stigma and improve work related outcomes. The key findings from the rapid review are outlined below:

- Mindfulness-based interventions currently have the greatest level of research evidence to support their effectiveness and were shown to reduce stress and anxiety and improve wellbeing and work performance, with positive effects lasting up to 1-year follow-up. However, evaluations using a randomised controlled trial (RCT) design were scarce, and therefore, these findings need to be interpreted with caution. Further research is needed to understand which intervention components are associated with effective delivery and whether mindfulness-based interventions can be delivered to more diverse groups of employees, including those working in male-dominated sectors.

- Cognitive Behaviour Therapy (CBT) interventions were identified as being effective for preventing depression at the workplace and can be successfully delivered in a variety of settings and formats. CBT interventions varied greatly in terms of their duration and content, with lack of knowledge on what factors contribute to effectiveness. Reviews of digital interventions reveal that stress

management and depression prevention interventions can be successfully delivered online, although high attrition rates may be an issue.

- Multicomponent anti-stigma interventions show potential in improving mental health related knowledge, attitudes and behaviour in employees and managers. Interventions to raise mental health awareness were found to increase help-seeking and reduce stigma. However, evaluations using an RCT design were scarce, and therefore, these findings need to be interpreted with caution. Studies on the impact of stigma reduction/mental health awareness interventions on actual employee mental health is limited, with the only review assessing this not reporting any significant outcomes.

- Organisational interventions that focus on flexible work-arrangements and emphasise employee participation and managerial support were shown to lead to improvements in work engagement. However, evidence on the effects of organisational interventions on employee mental health was limited. Review findings indicated that whereas individual interventions tend to show larger effects on individual outcomes, organisational interventions rarely target these outcomes.

- The majority of reviewed intervention studies were conducted in the health care or educational setting or in large, white-collar enterprises, with less evidence of the implementation of mental health interventions in SMEs or with blue-collar workers.

- There is evidence that a combination of approaches may be more effective than applying just one specific theoretical approach. Findings from the reviews of organisational interventions indicate that in order to achieve wider work-related outcomes, individual interventions need to be combined with wider organisational strategies.

Mapping Study

Twenty-seven voluntary organisations were identified as potentially providing mental health promotion supports to workplaces. Eighteen of these participated in the study. There were a wide variety of activities and supports provided, numbering 62 across the eighteen organisations. There was a clear commitment on the part of mental

health voluntary organisations to work with workplaces to facilitate the promotion of mental health, yet at times their role and relationship constrained them in what was proffered, requested and accepted. The key findings from the mapping study are outlined below:

- Voluntary organisations in Ireland providing mental health promotion interventions in the workplace are typically small organisations (i.e. 72% had under 50 employees). They support a variety of workplaces in size and sector. Support provided is at both an individual level and organisational level, employing mostly online and digital interventions (although the timing of the study, i.e., during the COVID-19 pandemic, must be noted).

- Individual-level interventions focused on mental health awareness-raising and stigma reduction. These are aimed at increasing awareness and developing skills to appropriately interact with vulnerable individuals. These were most commonly half-day, one-day or two-day mixed component programmes.

- Individual-level support aimed at promoting stress management or one-to-one psychotherapy counselling services and mindfulness or meditation-based interventions were less commonly reported. Where these are delivered, they are implemented by qualified professional staff within the voluntary organisation or through partnership with credentialed and experienced external facilitators. Structured depression prevention interventions, such as CBT-based approaches, were not reported.

- There was evidence of organisational-level interventions aimed at nurturing a mental health promoting workplace culture by enhancing manager skills and guiding workplaces to create policies and prioritising mental health promotion, although less common than once-off short duration educational interventions. Organisational-level interventions included informal approaches such as trust building and guiding workplaces toward evidence-based best practice, increasing awareness of managers' protective role in supporting mentally healthy workplaces, encouraging and supporting workplaces to create mental health policies, and providing toolkits and resources for creating healthy workplaces. Voluntary organisations also signposted workplaces to individual-

level interventions in lieu of individual-components built into organisation-level interventions.

- Many of the activities or interventions identified in the mapping study efforts are currently delivered online as either live interactions (video-conferencing, apps or social media) or pre-recorded digital libraries (podcasts, videos etc.) or resource hubs (toolkits, booklets, posters, infographics etc.).

- Most of the workplaces supported by voluntary organisations included banks, solicitors, retailers, multi-national corporations and other white-collar working environments, with less mention of male-dominated professions and blue-collar workplaces. Reported target audiences include all staff, manager-specific, corporate operations decision-makers (Human Resources or other policy developers) and self-employed.

Conclusions and Recommendations

A wide range of interventions can be successfully implemented in workplaces, as identified in the rapid review. The mapping study also identified a wide variety of interventions, activities and supports, a number of which aligned with evidence-based practice. Further opportunities to increase evidence-based approaches were uncovered.

Voluntary organisations are in a unique position to provide support to workplaces, having expertise in mental health promotion, mental ill-health treatment and recovery and access to a range of materials and interventions to support good mental health. This supportive role is part of the cross-sectoral approach advocated in *Connecting for Life*, the National Strategy to Reduce Suicide, (NOSP, 2015) and consistent with the National Healthy Workplaces Framework (forthcoming). However, much of what voluntary organisations are requested to do is opportunistic, and this was reflected in the findings of the study. There was a clear commitment on the part of mental health voluntary organisations to work with workplaces to facilitate the promotion of mental health, yet at times their role and relationship constrained their interventions. Based on the findings of the study, the following recommendations are made:

Awareness-raising educational activities be used as an entry point for voluntary organisations to facilitate engagement, with a view to on-going relationship building with workplaces and to steer workplaces toward more structured evidence-based approaches.

Building on current initiatives, anti-stigma and awareness raising events be developed to incorporate a more multicomponent and integrated approach, for which there is convincing evidence of effectiveness.

Voluntary organisations consider adding mindfulness interventions that have been demonstrated to be effective to their repertoire of offerings. Providing mindfulness and meditation-based interventions could provide an opportunity to engage workplaces on the topic of stress and to engage them further on addressing the organisational drivers of stress.

Voluntary organisations be supported to identify evidence-based integrated programmes, which combine personal, individually-focused interventions with organisationally-focused approaches.

The relationship-building approach taken by voluntary organisations be supported to facilitate the implementation of combined individual and organisationally focused stress prevention strategies, for which there is greater evidence of effectiveness.

To better support mental health voluntary organisations with regard to prevention of depression, a knowledge translation exercise to be undertaken to increase awareness of the effectiveness of CBT and other therapeutic interventions in the workplace and the conditions under which these approaches are effective.

A study to be undertaken to explore what barriers and facilitators may exist on the part of management with regard to the implementation of more structured evidence-based interventions for addressing depression and anxiety in the workplace. Further to this, a planned approach to implementing and evaluating depression and anxiety interventions be undertaken in partnership with voluntary organisations and clinical experts.

A specific knowledge translation exercise is recommended for voluntary organisations to identify the types of digital interventions that show effectiveness (and those that have not) in order to maximise the potential for the use of digital interventions. It is also recommended that workshops on how to evaluate the use of such interventions could facilitate voluntary organisations to contribute to the evidence base in this area.

Practices such as working with workplace champions or committees, and coupling strategies, such as combining fundraising or CSR policies with employee wellbeing initiatives, be considered as a basis for facilitating employee engagement and to embed mental health policy in workplace strategic policy.

Voluntary organisations are supported to establish links with SMEs and workplaces where blue-collar workers predominate, drawing on the types of interventions found to be effective in this review.

The findings of this study demonstrate that mental health voluntary organisations are committed to engaging workplaces and have provided a variety of activities and interventions to facilitate mental health in the workplace. The voluntary sector has a key role to play in advancing the implementation of current workplace wellness policies, including supporting the creation of supportive workplace cultures for improving mental health and wellbeing. This model of linking with voluntary organisations is, therefore, valuable and should be retained. However, despite apparent commitment on the part of the voluntary providers, it is also evident that more needs to be done to attain a more comprehensive and integrated approach to improving mental health and wellbeing in the workplace as advocated by current frameworks and available evidence. The majority of the supports provided are demand-led and are therefore, dependent on the willingness of workplaces to engage. The adoption of more structured, evidence-based approaches would enhance existing practice in the voluntary sector, especially with regard to addressing depression, anxiety and stress prevention at work. Integrated approaches are needed for workplace mental health promotion interventions to be successful, combining both individual- and organisational-level approaches that address the individual worker and the organisation as a whole.

The voluntary organisations are well positioned to build on current initiatives and the positive relationships that have already been established with workplaces. This would need to be supported at a national level in order that more strategic planning for the delivery of structured longer-term strategies could be undertaken.

The likelihood that workplaces do not fully grasp what workplace mental health promotion entails was highlighted in this study and this needs to be addressed. Promoting a greater awareness and understanding of the scope and potential of workplace mental health promotion is required. The forthcoming National Healthy Workplace Framework may help in this regard.

Critical to informing the sustainability of current service provision and long-term planning on expanding the range of services is investing in evaluation. Supporting the evaluation of current initiatives would enable organisations and workplaces to document and demonstrate impact in terms of indicators of employee mental health and wellbeing, and also in terms of reduced stress, absenteeism, and improved productivity and job satisfaction. Developing an evidence base of effective practice and positive outcomes in the Irish context would strengthen the case for workplaces nationally to engage with services that will promote the mental health and wellbeing of their employees. Training for mental health voluntary organisations could be considered in respect of seeking and evaluating evidence and providing basic skills or toolkits in evaluative methodologies to facilitate estimation of the impact of their interventions. Ideally workplaces need to work in partnership with voluntary organisations to effect robust evaluations of interventions.

The scope of this time-limited research project allowed a brief and general introduction to the workplace mental health promotion activities being undertaken within the voluntary sector. With the implementation of the National Healthy Workplace Framework, there is a unique opportunity to combine Corporate Social Responsibility policies and employee wellness initiatives in order to create a more compelling case for workplaces to engage with workplace mental health promotion initiatives and thereby ensure better health and wellbeing for their employees and greater efficiency for their organisations.

Keywords: Workplace, mental health promotion, mapping study, evidence review

Chapter 1 - Introduction

The workplace is well recognised as an appropriate setting for promoting health and wellbeing. Workplaces that support mental health and support people with mental disorders are more likely to reduce absenteeism, increase productivity and improve financial returns (WHO, n.d.). The COVID-19 pandemic has changed how we work with many staff working remotely away from direct contact and support from colleagues contributing to stress and anxiety. It is anticipated that the pandemic will have a negative impact on levels of depression, self-harm, and suicide globally (Kumar and Nayar, 2020) much of which may manifest in the workplace.

Key international bodies, such as the World Health Organization (WHO) and the International Labour Organisation (ILO) have consistently advocated worker health and wellbeing with the WHO extending the focus from the narrower field of occupational health to an emphasis on creating supportive environments for health and promoting evidence-informed practice. A number of international frameworks and guiding documents for best practice in workplace health promotion have been developed, for example 'Healthy Workplaces: Improving employee mental and physical health and wellbeing' (National Institute for Health and Care Excellence [NICE], 2017), and the WHO Healthy Workplace Framework and Model (WHO & Burton, 2010), and, taking into account the focus of this study, 'A guide for employers to promote mental health in the workplace' (Knifton et al., 2011) produced by the European Network for Workplace Health Promotion (ENWHP). The key elements of these frameworks focus primarily on structures and actions at the organisational level, consistent with literature that has consolidated the evidence base for effective workplace mental health promotion (Barry et al., 2019; Harvey et al., 2014).

The importance of an explicit commitment to promoting and protecting the mental health of employees is manifest in all frameworks. This commitment can be evidenced in various ways. The NICE quality standards (NICE, 2017), for example, include making a visible commitment through having a senior manager with a dedicated role for staff health and wellbeing. The focus on leadership is also seen in the WHO Healthy Workplace Model, where it is a core principle for protecting and promoting health and one which underpins the continual health improvement

process that forms the centre piece of the model (WHO & Burton, 2010). Both the WHO and NICE frameworks recommend the creation of a formal health and wellbeing policy, with objective metrics and processes for measuring progress, and a commitment to open communication of policy throughout the organisation.

All the frameworks underscore the importance of engagement with staff in developing health and wellbeing structures, including participation in decision making regarding their working practices and processes, and in particular those that have been identified as determinants of workplace stress (e.g., workload, demand, control etc.). The frameworks highlight the importance of taking a planning approach to the development of interventions to improve health, with the WHO framework describing a continual improvement process which draws on a ‘cycle model’, including mobilising and engaging key stakeholders, assembling a team to assess needs, participant-informed planning, intervention design and implementation, and continual evaluation to build in sustainability. There are also actions recommended at the level of individual units or staff, such as the provision of training to facilitate line managers to recognise and support workers who may be experiencing difficulties in addition to providing training to staff with regard to coping skills and providing appropriate support for those experiencing mental health problems. The WHO, NICE and the ENWHP all place emphasis on the importance of evidence–informed practice and policy.

Workplace Mental Health Promotion

There is a growing awareness of the role of work in promoting mental health, as the workplace is one of the key environments that affects our mental health and wellbeing. Investing in the mental health of the workforce is increasingly being recognised as being good for workers and for business. Promoting workers' mental health and wellbeing leads to increased commitment and job satisfaction, improved productivity and performance, staff retention and reduced absenteeism (Health and Safety Executive, 2009; WHO & Burton, 2010; World Economic Forum, 2016). Mental health problems, such as depression and anxiety, are the leading cause of sickness absence and long-term work incapacity in most developed countries (Joyce et al. 2016). The effects of stress and mental health problems in the workplace have significant impacts at an individual, organisational and societal level, due to loss in productivity, reduced performance or presenteeism, absenteeism, increased staff turnover, early retirement, and health care costs (WHO & Burton, 2010). While mental health problems such as depression and anxiety can be treated and in many cases can also be prevented, they may go unrecognised in the workplace and remain untreated, with consequent costs to the individual, employers and society. Mental health promotion in the workplace is, therefore, a critical strategy in improving outcomes for both individual employees and the organisation as a whole, leading to better mental health and wellbeing, reduced levels of absenteeism and presenteeism, increased productivity and job satisfaction. There is a strong social and economic case for investing in the mental health and wellbeing of the workforce (Goetzel et al. 2002; Knapp et al. 2011; World Economic Forum, 2016). Traditionally, however, many workplace health regulations and initiatives have placed more emphasis on physical health and safety issues in the workplace than on mental health.

The World Health Organization has clearly endorsed the need for a comprehensive and integrated approach to improving population mental health, embracing promotion and prevention, alongside treatment and recovery (WHO, 2013). A mental health promotion approach shifts the focus from a deficit model of illness to a broader understanding of mental health as a positive concept and a resource for living with relevance for the whole population. Mental health promotion brings a clear focus on the mental health potential of people and the everyday settings in which

they live and work. Mental health promotion is, therefore, concerned with achieving positive mental health and wellbeing by strengthening protective factors for good mental health, enhancing supportive environments and enabling access to resources and life opportunities for individuals and communities that will promote their social and emotional wellbeing (Barry et al., 2019).

Mental health promotion offers a distinctive framework for workplace mental health as it is concerned with the delivery of effective policies and programmes designed to improve workers' positive mental health and wellbeing and reduce mental health inequities. While prevention programmes are primarily concerned with the reduction of the incidence and prevalence of mental disorders, mental health promotion focuses on the process of enabling and achieving positive mental health and enhancing wellbeing for individuals, communities and society in general. In keeping with the fundamental principles of health promotion as articulated in the Ottawa Charter (WHO, 1986), this calls for integrated approaches including interventions at the level of individuals, communities and key settings, and 'upstream' policy interventions across the non-health sectors in order to reduce structural barriers to mental health. This perspective underscores the importance of developing supportive work environments for good mental health, re-orienting existing supports and services, and advocating for the development of mentally healthy workplaces.

The WHO 'Mental Health and Work: Impact, issues and good practices' (2000) report, advocated three main issues that employers need to address to promote the mental health of their employees. These include: (i) recognition and awareness of mental health as a legitimate concern of organisations; (ii) effective implementation of workplace policies and anti-discrimination provisions regarding the employment of people with mental health problems; (iii) understanding the need for early intervention and assistance programmes to meet employees' mental health needs, as well as reintegrating employees back into the work environment. Addressing each of these issues requires a comprehensive approach that takes account of the wide range of risk and protective factors that determine mental health in the workplace. Harvey et al. (2014) identified evidence-based risk and protective factors in the workplace that operate at the level of the individual (job demands and control, coping style, home-work conflict), work teams/groups (relationships, leadership, support) and at the organisation as a whole (organisational practices, policies, environment).

In order to create a mentally healthy workplace, strategies are needed to address these influencing factors at each level and this requires an integrated systems approach whereby change can be effected at the level of the individual and the organisation as a whole.

Mental health promotion strategies need to take into account the nature of the work, the workforce and the characteristics of the organisation (NICE, 2009), as different approaches may be needed by different sized workplaces and employee groups. Reviews of the evidence suggest that an effective workplace health improvement policy should include: promoting the mental health and wellbeing of all staff (promoting resources for positive mental health and reducing or eliminating stress), offering support and assistance to workers experiencing mental health problems in the workplace, and adopting a positive approach to employing and re-integrating workers with a history of mental health problems (Harvey et al., 2014). A strategic and coordinated approach to promoting employees' mental health is therefore required, including adopting a comprehensive organisation-wide approach, working in partnership with key stakeholders in integrating mental health in all workplace policies and practices concerning managing people, employment rights, and working conditions (NICE, 2009).

Synergising with National Policies

Developing and implementing a Healthy Workplaces Framework is a key element of the Department of Health's Health and Well-being Programme. The National Healthy Workplace Framework (forthcoming), links with Ireland's overarching national health and wellbeing policy, *Healthy Ireland* (Department of Health, 2013). The framework addresses the protection of workers from occupational illnesses and injuries and the promotion of their health and wellbeing in the daily conduct of their work. It provides a supportive flexible structure that can be applied across all workplaces, promoting evidence-informed practice. The framework is consistent with the WHO's perspective on the importance of addressing and supporting health in places where people spend their daily lives, as articulated in the WHO Healthy Workplace Model (WHO & Burton 2010). This National Healthy Workplace Framework (forthcoming) was informed by a comprehensive consultation with circa 1,700 workers, from which it emerged that mental health in the workplace is a priority issue. Mental health was ranked as the most important issue from a list of twelve issues, and one that

participants advocated to be explicitly included in the framework. Participants considered mental health and stress to be major issues in Irish workplaces, emphasising the role the workplace can play in both the creation of positive mental health and also in facilitating recovery from mental ill-health (McEvoy et al., 2018).

The National Healthy Workplace Framework is aligned with the national mental health policy, *Sharing the Vision* (Department of Health, 2020), which provides a framework to address mental health in Ireland through a whole-of-society, lifecycle approach. This national policy was developed following an extensive expert evidence review of international best practice in collaboration across sectors, throughout governmental committees, and in consultation with wider clinical and NGO experts and service users. *Sharing the Vision* recognizes the importance of a whole-systems approach where all sectors, not solely the health care sector, play their part in protecting and promoting public mental health (Department of Health, 2020). *Sharing the Vision* states that workplaces have a role in mental health promotion, reducing stigma and supporting individuals with mental health disorders. Consistent with the workplace health promotion frameworks from international bodies, organisational-level approaches are advocated. The policy calls for open discussion about mental health to promote overall organisational and individual wellbeing, with equal consideration for early intervention when mental health problems develop, and enhanced recovery and reintegration of people who have complex mental health difficulties.

The approaches advocated in the National Healthy Workplace Framework and within *Sharing the Vision* are consistent with the approach taken in *Connecting for Life*, the National Strategy to Reduce Suicide (National Office for Suicide Prevention, 2015). *Connecting for Life* recognises the need for a whole-of-government approach, working with a range of sectors and organisations, including workplaces and the community and voluntary sector. Mental health voluntary organisations are an important resource for workplaces, providing expertise in relation to specific topics and with regard to stigma reduction, a known barrier to supporting mental health in the workplace (Mental Health Foundation Scotland, 2018). In the context of the recognition of a need to build and improve relationships between the voluntary sector and state health care agencies (National Economic & Social Council, 2021) this way of working is likely to increase in importance.

Rationale for the Research

One of the major outcome enablers identified in *Sharing the Vision* is investment in the workforce, including the voluntary and community sector. In Ireland the sector constitutes 10,000 registered charities and more than 20,000 non-profit organisations or groups, employing 190,000 staff, c. 50,000 volunteer board members and over half a million operational volunteers (The Wheel, 2018). Mental health voluntary organisations have a critical role in progressing the actions identified in *Sharing the Vision*, and in being part of the whole-of-government approach within *Connecting for Life*. Mental health organisations in the voluntary sector offer a variety of supports and interventions to address mental health issues in the workplace and there is currently a significant demand from employers for support with all aspects of mental wellbeing. However, it is not known at this time the exact nature of supports and interventions that are being requested, offered or provided to workplaces by mental health voluntary organisations. To best support voluntary organisations in their role in facilitating workplace mental health promotion, it is important to identify what supports they are providing to workplaces, thereby contributing to enabling evidence-informed practice.

Research Aim and Objectives

The aim of this project is to map the range of mental health promotion supports and services that are offered by the voluntary sector to workplaces and to identify the most effective and feasible evidence-informed approaches that could be adopted to promote the mental health and wellbeing of workers in the Irish context.

Objectives of the project are:

- To identify key mental health organisations in the voluntary sector who provide supports to workplaces.
- To map the type and level of supports provided, including but not limited to: educational packages, workshops, training, advice, awareness events, strategy building, mental health literacy, structured programmes, and assistance in the evaluation of initiatives.
- To undertake a rapid review of the international evidence with regard to models of good practice in the provision of mental health promotion initiatives

in the workplace, in order to assist voluntary organisations to maintain a high level of evidence-informed practice.

In order to fulfil the objectives, the research was divided into two separate studies, a rapid review of the international evidence, and a mapping study of existing practice in the voluntary sector in Ireland. The methods, results and conclusions, identifying the who (target audience and programme implementers), what (programme components), where (setting) and how (implementation) interventions are delivered, for each study are presented respectively in Chapters 2 and 3. Chapter 4 draws on the synthesised findings from both studies to offer recommendations on how existing practices can be aligned with international evidence-based practice.

Chapter 2 - Rapid Review of the International Evidence

The rapid review of reviews will synthesise the international evidence on the effectiveness of workplace mental health promotion (WPMHP) interventions for improving employee mental health and work performance. The review findings will be used to identify evidence-based approaches that can be feasibly implemented by the voluntary sector delivering mental health promotion interventions to workplaces in Ireland. The interventions included in this review have a specific focus on improving mental health and wellbeing and/or work-life balance. While multicomponent wellness interventions and physical activity interventions have been shown to have positive effects on employee mental health, work performance and absenteeism (Bhui et al., 2012; Wagner et al., 2016), these will not be included in this review, the focus of which is on interventions designed explicitly to promote mental health and wellbeing.

The aim of Rapid Review is to review international evidence with regard to models of good practice in the provision of mental health promotion initiatives in the workplace, in order to assist voluntary organisations to maintain a high level of evidence-informed practice, and to identify the best strategies for investment.

The objectives of the review are:

1. To synthesise evidence on the effectiveness of workplace mental health promotion and prevention interventions.

2. To identify mental health promotion and prevention intervention approaches with a robust evidence-base of effectiveness that could be feasibly implemented in Ireland.

3. To identify the relevant implementation processes in relation to who (target audience and programme implementers), what (programme components), where (setting) and how (implementation) interventions are delivered.

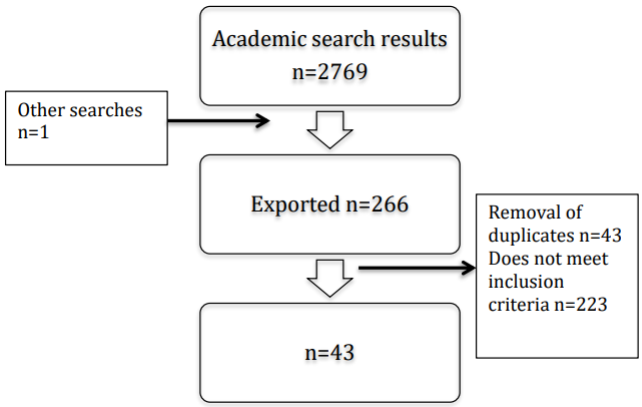
Methods

The study synthesised international evidence on the effectiveness of interventions to promote mental health in the workplace, based on a rapid review of systematic reviews, meta-analyses and second-order reviews. Both peer reviewed and grey literature published in the last 10 years (2010-2021) were included in the study. All searches were conducted in June-July 2021. The searched databases included Scopus, PubMed, ASSIA, Cochrane Database of Systematic Reviews and selected public health and occupational health and safety websites. The full search protocol can be found in Appendix 4.

Results

The search returned 2769 studies, of which 266 articles were exported based on their title. After removal of duplicates (n=43), the studies were screened and 109 met the inclusion criteria. Because of the unexpectedly high number of studies found, it was decided to exclude studies focusing on specific occupational groups (e.g., healthcare workers, teachers, prison correctional officers; n=37), physical activity interventions (n=7), interventions for traumatic stress (n=6), interventions to improve return to work in people with mental ill health (n=10), multicomponent wellness interventions (n=5), interventions implemented in Asian countries (n=3) and reviews focusing on health promotion interventions without an exclusive focus on mental health (n=2). Finally, 43 reviews were included in the analysis, of which 21 were meta-analyses and 20 were systematic reviews and 2 were second-order reviews. A flowchart of the searches is provided in Figure 1.

Figure 1. Flowchart of search results



Of the included studies, ten focused specifically on mindfulness/meditation interventions, ten examined prevention interventions for depression, anxiety and stress, seven focused on organisational interventions, four on digital interventions, four on anti-stigma and mental health awareness interventions, two on resilience training, and one each on nature-based interventions, self-compassion training, employee assistance programmes, coaching, interventions for subjective wellbeing and spiritual interventions. The outcomes examined in these reviews included negative mental health outcomes (depression, anxiety, stress, burnout), positive mental health outcomes (e.g., resilience, coping, mindfulness) and work-related outcomes (e.g., absenteeism, work engagement, work performance). A summary of the included studies is provided in Appendix 5.

Mindfulness/Meditation

Of the nine reviews on mindfulness-based interventions, there were six meta-analyses, one second-order meta-analysis and three systematic reviews. Some studies compared mindfulness-based interventions to other contemplative practices such as relaxation (Ravalier et al., 2016), Acceptance and Commitment Therapy (ACT) and other types of meditation (Slemp et al., 2019). Mindfulness-based interventions aim to bring greater awareness of the present moment by using meditation techniques such as body scan and breath meditation. They vary widely regarding duration (10-minutes self-guided meditations five days a week, to 42 hours class-time over eight weeks), delivery format (online, videoconferencing, audio-tracks, face-to-face), content (incl. meditation techniques, mindfulness theory, teachings about stress physiology) and frequency of home practice. The majority of interventions are based on Mindfulness Based Stress Reduction (MBSR; Grossman et al., 2004) which is a structured group-based intervention delivered over an eight-week period.

Findings from the studies indicate that mindfulness-based interventions, when delivered in the workplace, reduce symptoms of anxiety and depression, reduce stress and burnout, and improve mental wellbeing with effect sizes ranging from small to medium and lasting up to 1-year follow-up. However, these effect sizes may be inflated by publication bias and methodological issues in the primary studies. The beneficial effects of mindfulness on self-reported levels of stress are supported by a meta-analysis by Heckenberg et al. (2019) of nine studies on the physiological

effects of mindfulness interventions, indicating that they improved some, but not all, physiological indicators of stress.

Bartlett et al. (2019) conducted a meta-analysis of twenty-seven randomised controlled trials on mindfulness-based interventions on employee mental health and wellbeing. The study participants came from mainly large organisations and white-collar workforces from a range of occupational backgrounds, with education and training and health and community services being the most studied sectors. Men were consistently underrepresented, making up less than 15% of the entire sample. They found beneficial effects for mindfulness, stress, anxiety, psychological distress, wellbeing and sleep, and inconclusive evidence for depression, burnout and work performance due to publication bias and limited number of primary studies.

CASE STUDY: Mindfulness-Based Stress Reduction (MBSR)

MBSR teaches mindfulness practices with a specific focus on applying mindfulness during stressful events. The effectiveness of MBSR in reducing stress, depression and anxiety has been demonstrated with healthy adults in various settings, particularly among healthcare workers (Khoury et al., 2015).

Content: MBSR aims to decrease emotional reactivity and enhance cognitive reappraisal, thus changing an individual's reaction to stressful thoughts or events. MBSR provides training in mindfulness practices, such as body scan, sitting meditation and yoga and typically also includes psychoeducation. Specific focus is given to how to practice mindfulness during stressful situations.

Delivery: MBSR is typically delivered over 8-weeks, with one 2.5h session weekly and an additional one-day workshop (Grossmann et al., 2004). Home practice for 45 min/day is also encouraged. MBSR is delivered to groups of 10-40 participants by facilitators trained in mindfulness meditation.

Effectiveness: A meta-analysis of twenty-nine studies on the effectiveness of MBSR on healthy adults found large effects on stress, moderate effects on anxiety, depression, distress, and quality of life, and small effects on burnout (Khoury et al., 2015). The intervention was particularly beneficial for health care workers in comparison to community members and students. Notably, the majority (83%) of the participants were young females (mean age = 36.8).

Implementation: There is limited knowledge regarding the factors related to successful implementation of MBSR, with existing studies reporting a variety of delivery formats and amount of home practice. Findings from Khoury et al. (2015) suggest that clinical and/or mindfulness training among the facilitators is associated with better outcomes as is using the standard MBSR protocol (Kabat Zinn, 1990) instead of a modified version of the intervention.

Similarly, Pérez-Fuentes et al. (2020) conducted a meta-analysis of intervention studies (n=24) and reported significant intervention effects for mindfulness, anxiety, stress and negative affect, but not for depression, positive affect or resilience.

In another meta-analysis of randomised controlled trials, Lomas et al. (2019) reported moderate effect sizes for deficit-based outcomes (including anxiety, stress, depression, psychological distress and burnout) and small to moderate effect sizes for asset-based outcomes (including health, mindfulness, job performance, compassion and empathy, positive wellbeing). Similarly, Monzani et al. (2020) conducted a second-order meta-analysis and found mindfulness-based interventions to have stronger effects on reducing negative emotions than improving wellbeing. Additionally, Monzani and colleagues tested a mindfulness-based intervention against a mindfulness-based intervention with a complementary strengths-based component, consisting of focusing attention towards identifying and improving character strengths, and found the latter to be more effective in improving wellbeing.

There is limited knowledge about the factors affecting intervention effectiveness. Bartlett and colleagues (2019) did not detect significant moderating relationships for intervention dose, mode or content, or workforce characteristics. However, including micro-practices and mindfulness theory may have a positive effect on programme impact on stress, whereas the inclusion of yoga or stress physiology components showed no effect. Similarly, Vonderlin et al. (2020) examined factors attributed to programme effectiveness and did not find programme or participant characteristics to moderate outcomes. Ravalier et al. (2016) examined the effectiveness of different types of complementary therapies, and found support for mindfulness and meditation, but not for relaxation interventions. Slemp et al. (2019) examined the effects of mindfulness, meditation, ACT and combined interventions on psychological distress and found the strongest effects for meditation-based interventions, followed by mindfulness-based interventions with ACT having the smallest effects on psychological distress.

Depression, Anxiety and Stress Prevention

We identified four meta-analyses, five systematic reviews, and one second-order review focusing on psychological interventions for preventing depression, anxiety and stress at the workplace. The main approach used in the reviewed interventions was group-based cognitive behavioural therapy (CBT) delivered in groups. However, there was wide variability across these interventions, with 45min-120min workshops delivered on a twice weekly to once monthly basis, with some interventions also including homework assignments. Many CBT-based interventions were also complemented by other intervention components, such as communication skills training, psychoeducation and relaxation. Other approaches, such as interpersonal therapy and ACT, were less common. The interventions targeted employees from private and public sectors, with healthcare workers being overrepresented. One review focused specifically on small to medium enterprises (Hogg et al., 2021). Overall, the findings from the reviews indicate that CBT-based interventions, particularly when combined with other approaches and delivered universally, are a potentially effective way of preventing depression at the workplace.

Wan Mohd Yunus et al. (2017) conducted a review of universal and targeted interventions (n=22). Although CBT-based interventions were the most common type of intervention used at the workplace for preventing depression, interventions that used a combination of approaches were most effective. A universal intervention combining CBT and coping flexibility (Cheng et al., 2012) reported the highest effect size (d=1.45, 95% CI= 1,02, 1.88) for reducing depression of all included targeted and universal interventions. Most interventions using other therapeutic approaches were also effective, particularly those using a combination of different approaches. Interventions delivered in a group format showed lower attrition rates than interventions using other delivery formats.

Ihara and colleagues (2021) conducted a systematic review of RCTs on group CBT interventions for preventing depression at the workplace and found that eight out of the ten included studies reported significant effects on symptoms of depression and all ten studies reported significant effects on at least some aspects of work performance. The authors concluded that interventions that target employees from the same occupation, job position or workplace and allow participants to share their

work-related problems may be more effective in improving work related and mental health outcomes.

Hogg et al. (2021) synthesised evidence on the effectiveness of prevention interventions delivered specifically in small to medium enterprises. The study sample included employees, entrepreneurs, managers and those who were self-employed, with the majority of the participants across studies being male blue-collar workers. Five of the interventions were based on cognitive behavioural techniques, one consisted of psychotherapy using a range of theoretical approaches, and one intervention approach was unspecified. The interventions were self-administered or delivered face-to-face. The quality of evidence was low, with only three of the included seven studies employing a randomised controlled design. Five studies using a CBT approach reported significant effects on depression and anxiety. However, the three randomised controlled trials reported no differences in outcomes between the intervention and active control groups (including GP visit, psychoeducation and financial grant), indicating that the intervention outcomes may not be specific to the CBT approach.

Bellon et al. (2019) conducted a systematic review and meta-analysis of RCTs on universal educational and psychological interventions for preventing depression. Although these interventions were found to have statistically significant moderate effects on depression, the quality of evidence was low. Only three studies, which varied widely in terms of their theoretical background and mode of delivery (group intervention based on social cognitive theory, internet-based CBT, and a self-help book based on ACT), met the inclusion criteria, and were included in the review. In an earlier review, Tan et al. (2014) reviewed RCTs on universal depression prevention interventions at the workplace (n=10) and found an overall small positive effect for interventions on symptoms of depression, with CBT-based interventions showing greatest effects.

Three of the reviews focused specifically on indicated prevention interventions targeting individuals with mild to moderate symptoms of depression. Most recently, Nigatu et al. (2019) identified sixteen RCTs on the effectiveness of indicated depression prevention interventions at the workplace. Eight of the sixteen studies reported significant intervention effects on symptoms of depression, with effect sizes ranging from small to medium. Six of these effective interventions were CBT based,

however, the highest effect size (SMD= −1.32, 95% CI= −2.16, −0.48) was reported for an intervention based on the provision of supervised exercise (De Zeuuw et al., 2010). Higher effect sizes were reported for virtually delivered interventions (via telephone or the Internet) than for face-to-face interventions. Earlier studies have failed to find convincing evidence supporting the delivery of indicated depression prevention interventions at the workplace. Furlan et al. (2012) and Dietrich et al. (2012) reviewed interventions for workers with mild to moderate symptoms of depression. Both studies reported a limited number of high-quality studies, and therefore, were unable to recommend any workplace intervention for indicated/secondary prevention of depression, except for the French APRAND intervention (Godard et al., 2006), which combines diagnosis with psychoeducation.

Bhui and colleagues (2012) synthesised the evidence from systematic reviews and meta-analyses (n=23) on the effectiveness of individual and organisational interventions for depression, anxiety and absenteeism. The findings indicate that individual interventions had a greater effect on individual outcomes, and that CBT is more effective than other approaches (e.g., relaxation) in improving employee mental health. Organisational interventions showed mixed evidence of benefits and some individual occupational stress management interventions led to a deterioration in mental health and absenteeism.

Organisational and Work Engagement Interventions

There were two meta-analyses and five systematic reviews examining the effectiveness of organisational interventions. The reviews included a wide range of different types of interventions including interventions to improve job design and employment practices, interventions to improve the social environment, and training for employees and supervisors. Overall, the findings highlight the importance of wider organisational strategies, employee participation and managerial support, to improve work related outcomes.

Knight and colleagues (2019) conducted a systematic review of work engagement interventions, including personal resource building (focus on increasing personal strengths and resilience), job resource building (aiming to develop positive aspects of work environment), leadership training and health promotion (aiming to improve

employee wellbeing; mainly mindfulness-based interventions included in the review), with a specific focus on the underlying mediators and moderators of effectiveness. They found the strongest evidence for health promotion (including mindfulness) and job crafting (in which individuals have greater autonomy to fit the job characteristics to their needs) interventions, interventions including both a group and an individual component, and bottom-up rather than top-down interventions. Employee participation and manager support, implementation quality (fidelity, compliance and participant satisfaction), and wider national and organisational factors were found to moderate the effectiveness of work engagement interventions. In an earlier meta-analysis, Knight et al. (2017) found a small significant positive effect for work engagement interventions on measures of work engagement, with group-based interventions being most effective.

In another systematic review, Ropponen et al. (2016) synthesised evidence from experimental and longitudinal studies examining the effect of organisational practices on work-life balance. They found that effective interventions targeted working time, care arrangements and training for supervisors and employees. Flexibility, in terms of both working time and other arrangements provided for employees, and support from supervisors decreased work-family conflict, decreased stress, improved physical health and job satisfaction, and also reduced the number of absence days and turnover intentions. Notably, only four out of the eleven interventions included actual organisational change regarding work-time arrangements, the rest providing employee and/or supervisor training on personal resources. The training interventions were quite distinct, targeting, for example, parenting skills (Work-Place Triple P), cognitive reappraisal of work-life balance, or mindfulness. Only one intervention (Support, Transform, Achieve, Results (STAR); Kelly et al., 2014) targeted both work-related and personal resources, providing employee training to identify new work practices and processes, and supervisor training for supporting employees' personal and family lives and job performance. Effective implementation of organisational interventions was found to require employee involvement and engagement, managerial commitment, and integration into existing organisational systems.

Findings from a review by Daniels, Gedikli et al. (2017) indicate that employee wellbeing and job performance may be improved by interventions focusing on

training employees to improve their own jobs, training coupled with job redesign and system-wide approaches that simultaneously enhance job design and a range of other employment practices. However, there is limited evidence available, particularly regarding training managers, and overall, the findings across studies are mixed.

Daniels, Watson et al. (2017) conducted a systematic review to examine the effectiveness of interventions designed to improve the social environment at the workplace. These included interventions introducing shared social activities (n=6) and interventions aiming to improve fairness perception (n=2). All studies on social activities demonstrated a significant positive effect on wellbeing, mainly measured as job satisfaction. The majority (n=4) also reported significant improvements in social environment and job performance. There were no significant effects reported for interventions targeting fairness perception.

Watson et al. (2018) synthesised the evidence of learning interventions on employee wellbeing. These interventions targeted: 1) personal resources (n=22; incl. mindfulness, CBT, stress management, problem solving etc.); 2) professional capabilities (n=10; incl. conflict management and communication skills); 3) leadership skills (n=6), and 4) organisational performance (n=3; incl. team working and networking). Watson and colleagues found strong support for interventions targeting personal wellbeing resources, however, evidence for the other training interventions was inconclusive. In terms of leadership training and organisational level interventions, issues in terms of implementation and uptake of interventions were reported.

Digital Interventions

Three meta-analyses and one systematic review focused specifically on digitally delivered interventions for managing stress and improving mental health. The majority of these interventions offered either guided or self-guided CBT for stress or depression through a website/computer. Only a few intervention studies evaluating the effectiveness of mental health apps were included in the reviews. Regarding the study sample, just under half of the participants were male across the reviews, with participants mainly representing highly educated white-collar workers. The findings from the reviews indicate that digital interventions are effective in reducing levels of

stress, anxiety and depression and improving wellbeing and work effectiveness, however, findings regarding the most effective approaches are mixed.

In the most recent meta-analysis, Phillips et al. (2019) synthesised evidence from thirty-four e-mental health interventions. Moderate treatment effects were reported for stress and burnout and small effects for depression, anxiety, wellbeing and mindfulness. Phillips and colleagues draw attention to the high attrition rates (<20%) in most studies and report significantly larger effects for interventions that include guidance and are based on problem solving therapy.

Carolan et al. (2017) conducted a meta-analysis of twenty-one RCTs of web-based psychological interventions for stress, depression and anxiety. They found an overall small to moderate effect of interventions on mental health and work efficacy. Over a half (57%) of the interventions were based on CBT, with the remaining interventions applying a wide range of theoretical approaches, including stress and coping, mindfulness, social cognitive theory, problem solving training, positive psychology and ACT. Unlike in the meta-analysis by Phillips et al. (2019), no statistically significant difference was found in outcomes between interventions based on CBT or other approaches, offering guidance compared with self-guidance, or recruiting from a targeted workplace population compared with a universal workplace population. However, interventions that that are delivered over a shorter period (6-7 weeks), use secondary modalities (e.g., email or text messages) for support and programme delivery and use persuasive technology, may achieve better adherence and engagement rates.

In another meta-analysis of controlled trials (n=23), Stratton et al. (2017) found larger short-term effects for mindfulness-based interventions than for stress management-based interventions. Furthermore, stress management interventions were more effective when used as targeted rather than universal interventions. Kuster et al. (2017) compared the effects of a face-to-face and a digital stress management intervention, however, they were unable to draw any definite conclusions due to low quality of evidence.

Anti-Stigma and Mental Health Awareness Interventions

Two meta-analyses and two systematic reviews focused on interventions targeting mental health related stigma and awareness. Most of these interventions consisted of multiple components, including mental health awareness raising among managers and/or employees, gatekeeper training, coping skills training, and wider organisational strategies to support employees with mental health challenges. One of the systematic reviews (Milner et al., 2014) focused specifically on suicide prevention strategies, however, the intervention approaches were similar to the anti-stigma interventions. There was a limited number of RCTs examining the effectiveness of stigma reduction interventions, with most studies employing a pre-post or quasi-experimental study design. Nevertheless, the findings from the reviews demonstrate the potential of anti-stigma interventions particularly in improving knowledge and attitudes related to mental health problems.

Dobson et al. (2019) reviewed evidence from eight studies assessing the effectiveness of the Canadian Working Mind intervention (Castro et al., 2015). The basic programme addresses issues related to stigma in the workplace, the use of a mental health continuum model to evaluate signs and indicators of mental disorder, and the development of coping skills. A manager version further addresses issues such as how to work with an employee who struggles with mental health issues, workplace accommodations, and overall management issues. The studies report moderate reductions in stigma and increased self-reported resilience and coping abilities and the findings were consistent across settings and different target groups. However, all the included studies employed a pre-post design, with no RCTs available to endorse these findings.

Gayed et al. (2018) conducted a meta-analysis of controlled trials (n=10) on the effectiveness of mental health training for managers. Significant positive effects were reported on managers' mental health knowledge, non-stigmatising attitudes towards mental health and improving behaviour in supporting employees experiencing mental health problems. However, only a small number of studies measured intervention effects on employee mental health, with no significant effects detected in these studies.

Hanisch et al. (2016) conducted a systematic review of controlled trials on workplace anti-stigma interventions, with most of the identified interventions (n=16) targeting managers. Two studies targeted employees working routinely with people with mental health difficulties (e.g., housing agencies). Half of the studies examined the impact of Mental Health First Aid. The studies indicate that anti-stigma interventions at the workplace can lead to positive effects on employee knowledge and supportive behaviours towards people with mental health difficulties, with findings regarding change in attitudes being mixed but generally positive.

Milner et al. (2014) reviewed suicide prevention interventions at the workplace. Of the thirteen included interventions, only five had been evaluated, mainly using a pre-post design. Of these five interventions, two targeted high-risk occupational groups (army and police-force) and showed reductions in suicidal behaviour over an 11- and 13-year period. These were multimodal interventions including education and training, awareness raising and policy change. One Employee Assistance Programme (EAP) reported improvements in suicidal ideation over a two-year period. Two interventions reported significant improvements in knowledge, stigma and help-seeking. One of these, the 'Mates in Construction' (Gullestrup et al., 2011), was evaluated with a quasi-experimental design, and consists of education and training of all construction workers, a buddy system and gatekeeper training.

Other Interventions

Eight reviews were identified that examined the effectiveness of specific types of workplace interventions including resilience training, nature-based interventions, spiritual interventions, interventions for subjective wellbeing, self-compassion training and EAPs.

Vanhove et al. (2016) conducted a meta-analysis on the effectiveness of resilience training interventions (n=37). Most of these interventions were universal interventions delivered in a group setting, however, the theoretical approaches used are not specified. Other delivery formats included one-to-one coaching, computer-based interventions and Train-the-Trainer interventions. Overall, the interventions were found to have a small effect on wellbeing, psychological deficits, and work performance, which diminished over time. The strongest effects were reported for interventions employing a one-on-one delivery format (e.g., coaching), followed by

interventions employing a classroom-based group delivery format. Programmes using Train-the-Trainer and computer-based delivery formats were least effective. These findings are consistent with a systematic review by Robertson et al. (2015) and a meta-analysis of coaching interventions (Theeboom et al., 2014) reporting medium to large positive effects on work performance, work attitudes, coping, wellbeing and goal-directed self-regulation.

CASE STUDY: Working Mind

The Working Mind is an evidence-based multicomponent intervention for promoting mental health and reducing stigma around mental ill-health. The intervention was developed in Canada and is supported by the Mental Health Commission of Canada. There are tailored interventions available for the health care sector, first responders, professional sportspeople, young people and for online delivery. For further information, please see www.theworkingmind.ca

Content: The intervention is based on the mental health continuum model, aims to increase mental health awareness, reduce stigma around mental ill-health, improve resilience and coping and create a more supportive working environment (Castro et al., 2015). There are separate courses for the employees and managers. The Employee Course provides psychoeducation on mental health awareness and coping strategies, whereas the Manager Course also aims to improve managers' knowledge around how to support employee mental health, highlighting managerial obligations towards those reporting mental health difficulties.

Delivery: The courses are delivered by trained facilitators over 1-2 days. The Employee Course is delivered over 4 hours and the Manager Course consists of 8 hours. Both courses are accompanied by workshop manuals and incorporate videos, group discussions, and personal goal setting. The preferred delivery format is the train the trainer model, with a five-day training course required for facilitators of The Working Mind courses.

Effectiveness: A meta-analysis of eight intervention studies showed moderate reductions in stigma and self-reported resilience and coping abilities (Dobson et al., 2019). However, the evaluation studies all applied a one-group experimental design with measurements taken at pre- and post-intervention and 3-month follow-up. There was low variability in outcomes across the various implementation sites, indicating that the intervention can be successfully rolled in diverse workplace settings.

Implementation: Dobson and colleagues (2019) reported that the programme has generally been received well by participants, with nearly 70% indicating that they are actively using what they learned from the intervention. Although the intervention has been delivered in various workplace settings in Canada, most of the evaluations are among white-collar workers, and little is known about the generalisability of the findings to other workplaces or country contexts. Furthermore, the effect of different delivery formats (train-the-trainer vs. outside facilitators) on programme effectiveness has not been examined.

Joseph et al. (2018) conducted a systematic review of intervention studies (n=17) on the impact of EAPs on employee wellbeing, absenteeism and presenteeism. Of the included seventeen studies, only five used a study design with a control group, with the rest employing a within-group design with measurements at pre- and post-intervention or post-intervention only. The majority (n=13) of the interventions solely involved the EAP counselling service, with the remaining studies evaluating a combination of secondary and tertiary prevention strategies or the EAP service as a whole. Absenteeism and presenteeism were the main outcomes of interest, with few intervention studies including outcome measures of health and wellbeing. The findings indicate that EAPs may result in positive employee outcomes, particularly presenteeism and functioning, although the quality of evidence is low.

Findings for nature-based interventions (Gritzka et al., 2020), spiritual interventions (Tai Chi, Reiki, yoga, Qigong, religious activities, spiritual meditation and workshops; De Diego-Cordero et al., 2020) and self-compassion training (Kotera & Van Gordon, 2021) were generally positive, although the limited number of studies, heterogeneity in interventions and methodological issues may hinder more robust conclusions.

Summary

The overall findings from the Rapid Review will be discussed here in relation to the what (programme components), where (setting), who (target audience and programme implementers) and how (implementation) of the most effective intervention approaches identified in this review.

What

The findings from this rapid review indicate that a wide range of mental health interventions can be effectively delivered at the workplace to improve employee mental health and work-related outcomes. No intervention approach was reported to have consistently negative effects on mental health or work performance; however, detrimental effects were reported in some individual interventions (Bhui et al., 2012). There was great heterogeneity in interventions within the different categories, with limited evidence of the intervention characteristics that contribute to programme effectiveness.

Of the types of interventions covered in the reviews, mindfulness-based interventions seemed to have the greatest level of research evidence to support their effectiveness, reflecting the increased interest in mindfulness for improving mental health and wellbeing in the western world. There were ten systematic reviews and meta-analyses focusing specifically on mindfulness and meditation interventions, all being published within the last five years. Mindfulness-based interventions were shown to reduce stress and anxiety and improve wellbeing and work performance, with positive effects lasting up to 1-year follow-up. There was some indication that mindfulness is more effective for deficit-based outcomes than asset-based outcomes (Lomas et al., 2019; Pérez-Fuentes et al., 2020; Wan Mohd Yunus et al., 2017). However, there was great variability in intervention content and delivery, with no conclusive evidence regarding what makes an effective intervention.

In relation to the depression prevention interventions, most were based on CBT and delivered in a group setting. The more recent reviews reported significant effects of small to moderate effect size for targeted and universal interventions, although the quality of evidence was low in most studies. Similar to the mindfulness interventions, the CBT interventions varied greatly in terms of their duration and content, with lack of knowledge on what factors contribute to effectiveness (Wan Mohd Yunus et al., 2017). Other approaches, such as ACT and interpersonal therapy, were also shown to be effective in individual studies (Bellón et al., 2019; Nigatu et al., 2019; Wan Mohd Yunus et al., 2017).

Organisational interventions that focus on flexible work-arrangements and emphasise employee participation and managerial support were shown to lead to

improvements in work engagement. However, evidence on the effects of organisational interventions on employee mental health was limited. Bhui et al. (2012) highlight that individual interventions show larger effects on individual outcomes, whereas organisational interventions rarely target these outcomes.

Interventions to raise mental health awareness, increase help-seeking and reduce stigma were shown to lead to improvements in knowledge, attitudes and in some cases, behaviours. However, evaluations using a RCT design were scarce, and therefore, these findings need to be interpreted with caution. Furthermore, studies on the impact of stigma reduction/mental health awareness interventions on employee mental health is limited, with the only review assessing this not reporting any significant outcomes (Milner et al., 2014). The findings from the reviews of digital interventions demonstrate that stress management and depression prevention interventions can be successfully delivered online, although high attrition rates may be an issue.

Finally, there were a range of intervention approaches focused on wellbeing, that showed potential for improving employee mental health and work performance, however, there was a limited number of high-quality evaluation studies on which to base more robust conclusions concerning their effectiveness. Of these, coaching interventions seem to have the most evidence to support their delivery.

Overall, the findings across the reviews indicate that using a combination of approaches may be more effective than applying just one specific theoretical approach. For example, in an experimental study, Monani et al. (2021) reported larger effects for an intervention combining mindfulness with a strengths-based component than a traditional mindfulness intervention. Wan Mohd Yunus et al. (2017) found stronger evidence for CBT-based interventions when combined with other theoretical approaches. Findings from the reviews of organisational interventions indicate that in order to achieve wider work-related outcomes, individual interventions need to be combined with wider organisational strategies that support employee autonomy and work-life balance.

Where

The review findings illustrate that workplace mental health interventions can be successfully implemented with a range of occupations in the public and private sectors. However, there is less evidence on the implementation of mental health interventions in SMEs or with blue-collar workers, with the majority of intervention studies conducted in the health care or educational setting or in large, white-collar enterprises. Hogg et al. (2021) reviewed depression prevention interventions implemented specifically in SMEs. Many of these enterprises represented blue-collar, male dominated industries, such as construction, mining, metal forging and farming. Although methodological issues and high attrition were reported in many of the studies, findings from the review indicate that CBT-based interventions can be an effective way to prevent depression in SMEs.

It is also clear that mental health interventions for depression, anxiety and stress can be successfully delivered online, however, again there is limited evidence on the implementation of digital interventions in worksites with mainly blue-collar workers. Furthermore, there is limited evidence on the effectiveness of interventions delivered through mobile apps.

Who

The interventions were mainly implemented with highly educated white-collar workers. Furthermore, in the case of mindfulness-based interventions, the target group consisted mainly of females, however, the study participants were more equally distributed across genders in the other types of workplace interventions. Of the studies that examined participant related factors on programme effectiveness, no significant moderating factors could be detected (Bartlett et al., 2019; Philips et al., 2019). Ihara and colleagues (2021) suggested that targeting employees from the same occupation, job position or workplace and allowing them to share their work-related problems may be more effective in improve the effectiveness of psychological interventions.

Most of the interventions targeted employees, apart from organisational and stigma reduction interventions, many of which were targeted towards managers, or both managers and employees. Stigma reduction interventions that aimed to improve

managers' mental health knowledge, attitudes and behaviour, although showing significant effects on managers' mental health related knowledge and attitudes, did not result in significant effects on actual employee mental health (Gayed et al., 2018). This combined with the findings from reviews of organisational interventions regarding the importance of employee participation and managerial support, highlights the need for comprehensive interventions that involve multiple stakeholders.

Most of the interventions were delivered by outside agencies. Psychological interventions for preventing depression and stress were mainly delivered by mental health professionals, whereas mindfulness-based interventions were mostly delivered by trained facilitators with experience of meditation practice. However, the reviews on digital interventions indicate that most mental health and wellbeing interventions can also be delivered successfully online with support or as fully self-administered interventions. There was also support for coaching interventions particularly for improving resilience, coping and work performance (Theeboom et al., 2014; Vanhove et al., 2016).

How

Overall, there were limited evidence available on how mental health interventions are best delivered in workplaces, however, the importance of support and guidance for employee engagement was reported in many reviews. In terms of mindfulness-based interventions, no significant implementation factors moderating intervention effectiveness were found (Bartlett et al., 2019). Findings were similar regarding depression prevention interventions, although group-based delivery may be linked to better engagement and lower attrition rates (Wan Mohd Yunus et al., 2017). In the case of digital interventions, offering support, limiting the duration of the intervention, and using persuasive design technologies were associated with better engagement rates.

The findings from the reviews of organisational interventions emphasise that, in order to achieve positive work-related outcomes, individual mental health interventions need to be complemented by wider organisational strategies. Furthermore, it is essential that interventions use a bottom-up approach that improves employee autonomy over their own work practices, emphasises employee

participation, is supported by managers and embedded in organisational structures (Daniels, Gedikli, et al., 2017; Knight et al., 2019).

Conclusion

The findings from the Rapid Review demonstrate that a wide range of interventions can be successfully implemented in workplaces to promote employee mental health and wellbeing, reduce mental health related stigma and improve work related outcomes. Mindfulness-based interventions currently have the greatest level of research evidence to support their effectiveness, particularly in terms of reducing stress and anxiety. However, further research is needed to understand which intervention components are associated with effective delivery and whether mindfulness-based interventions can be delivered to more diverse groups of employees, including those working in male dominated sectors. CBT is the most common type of intervention used for preventing depression at the workplace and can be successfully delivered in a variety of settings and formats, although digital delivery without support is likely to result in higher attrition rates. Multicomponent anti-stigma interventions show potential in improving mental health related knowledge, attitudes and behaviour in employees and managers, however, there is limited evidence on their impact on employee mental health and wellbeing. Finally, in order for individual interventions to have wider work-related outcomes, they need to be complemented by organisational strategies that emphasise employee involvement and engagement, managerial commitment, and integrating interventions into existing organisational systems.

Chapter 3 - Mapping of Existing Supports & Interventions offered to Workplaces by the Voluntary Sector in Ireland

In order to align current workplace mental health promotion activities within the voluntary sector to best practice within the international literature it is important to gain an understanding of what approaches and types of interventions and supports are currently being used in practice. The objectives of the mapping study are:

- To develop a list of organisations within the voluntary sector (VO List) that provide such targeted services.
- To map the landscape of existing services or supports offered by these voluntary organisations by conducting electronic surveys and virtual consultations.
- It is important to note that the mapping study is based on the responses received from available representatives within the voluntary organisations in the short timeframe allotted for this research study (which fell within summer months).

Methods

Developing the List of Voluntary Organisations

Developing the VO list presented a set of challenges not uncommon in research of this nature (Donoghue et al., 2006). Firstly, the inclusion criteria for categorisation as a 'voluntary organisation' is that they are formal or organised, non-governmental, non-profit, self-governing and voluntary (Salamon & Anheier, 1992). Secondly, to our knowledge, there is no comprehensive list or database of voluntary organisations with accurate and navigable classifications of the types of services offered. Not all organisations that fall into the mental health classification of non-profit organisations offer their services specifically to workplaces. Thus, a mixture of approaches was used to generate the comprehensive VO List including consulting online database listings and recommendations by recruited participants. Additionally of note, organisations that are classified as voluntary receive governmental funding and may

accept payment from certain larger corporate clients if, for example, the size of the corporation (and thus service required) is larger than the capacity of the voluntary organisation.

The list was generated in large part through snowball recommendations by voluntary organisations within the National Office of Suicide Prevention (NOSP) network. This was strongly facilitated by attendance at a monthly Non-Governmental Organisation (NGO) meeting where a member of the research team was able to outline the research and personally invite voluntary organisations to participate. Additionally, a database provided by the Charity Regulator was assessed to cross-reference organisations that had been recruited through word-of-mouth in order to find a degree of saturation in recommended organisations.

The specificity in purpose of our research allowed the sample size to be representative of itself. In other words, firstly, the natural unfolding of eligible organisations was an exercise in itself in staking the landscape of the voluntary sector who have found their role in supporting workplaces with mental health promotion. Secondly, the sample size justified itself since our research was aimed at supporting the very organisations who were the source of our data. Furthermore, the diverse and in-depth nature of our enquiry (electronic survey coupled with virtual consultations) complimented the smaller sample, in that it allowed for increased familiarity with the data leading to more rigour in data analysis (Vasileiou et al., 2018). Due to saturation achieved through recommendations by key informants across sectors, and through cross-reference with The Charity Regulators database, to our knowledge, we have identified the entire sample frame of voluntary organisations providing mental health promotion to workplaces in Ireland.

Mapping of Existing Supports and Interventions

A pilot study was conducted with two voluntary organisations. Their feedback was used to improve the survey's navigability and user-friendliness. Their data were used as part of the study findings and a follow-up virtual consultation was also conducted with each organisation involved in the pilot.

Initial data were collected electronically via a short survey (Appendix 1) sent to all participants within the VO List. A second set of data were collected through virtual consultation with participants. These consultations allowed for additional details and

clarifications, along with a more comprehensive and nuanced understanding of each participant's experience in implementation of interventions and supports. The prompting points used to direct the flow of conversation in these semi-structured virtual consultations is included as Appendix 2.

Analysis was driven by the survey and interview responses and consolidated into categories that matched the questions from the data instruments. Responses that differed in wording but similar in meaning were placed within assigned categories and where appropriate, details of these decisions are made explicit within the Results section below and detailed in Appendix 3.

Results

Ultimately 27 organisations were added to the VO List and eighteen organisations participated in the study (Appendix 3, Table 3-a). A classification of how the list was generated is included in Table 1. All voluntary organisations were invited to participate in both the electronic survey and in the virtual consultation. Of the eighteen participating organisations, seven submitted the electronic survey solely and a further five solely participated in a virtual consultation. Six organisations both submitted the electronic survey and followed up with a virtual consultation. As such, the total number of electronic survey responses included in the data was thirteen and the total number of virtual consultations held was eleven, resulting in 24 data sets. Following is a detailed presentation of the data gathered from the participating voluntary organisations.

Table 1. Development of list of voluntary organisations offering mental health promotion supports to workplaces in Ireland

Source of Contact	No. Organisations Contacted	No. Ineligible*	No. Did not respond	No. Resulting Participants
NOSP Direct Contact	4	0	2	3
Recommendations from NOSP Direct Contacts	3	1	0	2
NOSP NGO Meeting	17	4	5**	8
Recommendations from Organisations at NOSP NGO Meeting	8	0	3**	5
TOTALS	**32**	**5**	**10**	**18**

* Ineligible organisations are those that offer mental health supports, however the workplace setting is not within their remit.

** Of these organisations it is difficult to ascertain which should be added to the VO List as they did not respond to numerous contacts and may or may not offer mental health supports to workplaces.

Profile of Voluntary Organisations and the Workplaces they Support

Voluntary organisations were asked about their main focus and responses fell within the areas of support, education and training, and awareness and engagement. Education and support is typically offered under a general mental health category, with more targeted support provided for suicide prevention, the LGBT community, and individuals experiencing depression or homelessness. Less commonly reported were supports for mental health recovery, workplace advice or counselling on Employee Assistance Programmes (EAPs), and providing accessible and affordable services and resources (in one case, specifically for those within the creative industry who are typically self-employed). Training to enable appropriate interactions and communications with individuals who are experiencing mental health distress was also reported. Most commonly cited awareness efforts focused on stigma reduction of mental health and suicide but also on the positive encouragement of mental health. Other more specified awareness and engagement efforts are within the LGBT and youth communities as well as targeting engagement of men and young men. A summary of responses that fell within each of these categories is included in Appendix 3 (Table 3-b).

The size of the voluntary organisations varied significantly from one to 360 employees. Most organisations, however, fell within four to 50 employees (n=13 or 72%). The implementation department size was mostly under seven employees (n=15 or 83%) with two organisations having between 25 and 30 employees dedicated to implementation. Seven organisations had only one or two implementation employees. Some organisations reported the use of volunteers and interns for help in implementation.

No clear distinction emerged regarding the type of workplaces that typically engage in workplace mental health supports from the voluntary sector. The private sector (n=7) was commonly cited as having a very slight edge over the public sector in voluntary organisation clientele (n=2), with a very even split between the two cited by four organisations (a fifth organisation focused on self-employed individuals and four organisations did not answer).

It was also difficult to find a clear distinction between the size of workplaces reaching out for mental health supports as answers were split evenly. It was perceived that

large companies are more likely to be open to the WPMHP concept as they have more capacity (both financially and resourcefully), they typically have charity committees or Corporate Social Responsibility goals, they are part of wider conversations (multi-national organisations or global franchises), and they have that critical mass needed to make engaging staff a worthwhile endeavour.

Intervention Specifics

Nine organisations reported employing integrated approaches to their supports and interventions. Seven organisations reported that their approach is focused solely on the individual, with two organisations reporting their approach as being organisation-focused. Most presented the view that in targeting or supporting individuals, this facilitates a wider supportive environment in workplaces, which is what they aspire to.

Types of Interventions

Interventions and supports reported by participants included interactive or skills-based supports, educational supports with resources, public awareness-raising, and other supports such as one-to-one counselling or other services. A summary of specific responses is included in Table 2 and discussed below (more detailed responses are found in Appendix 3, Table 3-c).

Many interventions offered by the voluntary sector are aimed at teaching skills that enhance the capacity of the target audience or are aimed at guiding their interactions with individuals who may be experiencing mental health challenges. Many of these trainings include elements of role-playing to practice their newly acquired skills in a controlled environment. Educational sessions are often enhanced with interactive segments including group exercises, experiential practices and Question-and-Answer sessions. Pedagogical approaches are used in the form of workshops and educational talks and resources are provided to workplaces including practical toolkits and catalogues of booklets, brochures, posters, worksheets, packs, videos, podcasts and accessible dissemination of current research. One organisation offers a six-step pledge programme to help workplaces create an open culture and play a role in challenging mental health stigma. Voluntary organisations also included their general public awareness activities as a type of more general workplace support. Various campaigns and awareness promotions are used to further the WPMHP

agenda and include special events such as television and radio show appearances and popular viral community events.

Organisations reported offering policy and practice advice including legislative guidance, EAP-specific counselling, as well as individual psychotherapy counselling, and online and social media support (both with additional technical guidance), helpline supports, text message services and peer support groups or mentorship programmes.

Table 2. Summary of responses regarding types of interventions

Interactive or skills-based	**No. Reponses**
Training (skills)	11
Educational, interactive (Q&A's, group exercises) & experiential as well as role-play	6
Support services	**No. responses**
Online or apps with technical support, helplines, text message support	7
Advice (including policy/practice advice & EAP counselling & support)	6
Individual counselling services, peer support group/ mentorship programmes	4
Educational & Resources	**No. responses**
Workshops	17
Toolkits & catalogues of booklets, brochures, posters, worksheets, packs, videos, podcasts, research etc.	4
Public awareness activities	**No. responses**
Campaigns, events, awareness, promotion, special events to spread the work (e.g., Darkness to Light, Connect Café, television or radio appearances)	7

Aims of Interventions

When asked about the overall aim of their WPMHP efforts, responses fell into the following categories: supporting vulnerable individuals, awareness and stigma reduction, accessing resources, sector-specific aims, targeting workplace culture, stress resiliency, recognising mental health distress, and job-skills training. A summary of specific responses are included in Table 3 and discussed below (more detailed responses are found in Appendix 3, Table 3-d).

Most commonly cited intervention aims include skills to provide supports to individuals that are experiencing mental health distress (e.g., employees that disclose mental health vulnerability or how to aptly communicate in a crisis). The aim of these interventions is for target audience participants to gain skills to recognise, understand, interact with and support those in need, and to learn how to effectively signpost to additional services and encourage early help-seeking. Additional aims include imparting skills to be supportive and approachable, and the importance of being an empathetic ally or champion for those who are at-risk or may be experiencing mental health hardships.

Almost all voluntary organisation WPMHP interventions and supports include an element of awareness-raising and stigma reduction. Strategies included enhancing awareness of the voluntary organisation's cause and message, creating an open and empathetic environment, increasing awareness of the risk and protective factors of mental health while also empowering employees to sustain good mental health, and, in one case, imparting a keener awareness of the social determinants of health in order to prompt a more holistic comprehension of an individual's circumstances to guide a more empathetic and appropriate approach to engaging with vulnerable populations (see the Online Workshops for Managers and Employees in Promoting Positive Mental Health and Wellbeing Case Study on Page 54).

Intervention aims are also focused on encouraging workplaces to prioritise creating a positive mental health culture, including policies and top-down practices that encourage inclusiveness, openness, acceptance and appropriate workplace interactions while creating a safe space to voice sensitive concerns. One voluntary organisation aimed to equip workplaces with skills and resources to create an open culture and challenge mental health stigma (including Action Plans, policy templates,

legislative guidance etc.; See the See Change in Your Workplace Case Study on Page 59).

CASE STUDY: Online Workshops for Managers and Employees in Promoting Positive Mental Health and Wellbeing

Mental Health Ireland offers a suite of workshops targeted to workplaces and developed through extensive literature reviews by qualified and experienced staff and in coproduction with target audiences or intra-sectoral partnership. At the start of negotiations with workplace wellness representatives, Mental Health Ireland encourages workplaces to develop a mental health policy to embed consistent and sustainable efforts in promoting mental wellbeing in their staff. In addition to providing supporting materials specific to each workshop and general Mental Health Promotion resources, Mental Health Ireland provides a directory of Irish-based support organisations should participants need further support. Workshops are evaluated via participant feedback forms and at times through post-workshop consultations with workplace wellness representatives.

Intervention aim: The workshops aim to promote positive mental health by educating and training people around different aspects of mental health and providing them with the knowledge and tools to enhance their own mental health.

Content: The workshops follow an online universal template that is tailored to the specific culture and demographics of each workplace. Following is a description of each workshop offered:

Five Ways to Wellbeing Workshop or Webinar. The aim is to support participants in defining what mental health and wellbeing is and to improve their understanding of how they can look after their wellbeing during the COVID-19 pandemic. The workshop explores the application of the Five Ways to Wellbeing as a helpful coping strategy during difficult times: to connect, be active, take notice, keep learning, and give.

Virtual Connect Café. The aim of the virtual café is to open up conversations to help the participant to connect with themself and their colleagues.

Mental Health and Wellbeing Managers Workshop. This interactive workshop aims to support managers to gain some of the knowledge necessary to nurture and enhance mental health in the workplace and to adopt and enhance practical supports to maintain mental health. The workshop aims to challenge perceptions of mental health and encourage reflection of their own perceptions, while looking at their own self-care and boundaries and examining what impacts both negatively and positively on mental health. The workshop offers guidance on how to generate, facilitate and engage in conversations about mental health and to understand how to support an employee who discloses that they are experiencing a mental health challenge.

Mental Health and Wellbeing Employees Workshop. This interactive workshop aims to support participants to understand and explore the knowledge necessary to foster and enhance mental health and wellbeing in the workplace, to explore and challenge perceptions on mental health, and aims to demonstrate how to have conversations about mental health in the workplace. Participants are supported in examining what impacts both negatively and positively on mental health and are provided with practical tips to improve and sustain wellbeing.

Alcohol and Mental Health Workshop. The workshop provides an opportunity for participants to explore their own relationship with alcohol, increase their awareness of the impact of alcohol on mental health and to identify ways to look after their wellbeing. The workshop was co-produced with Alcohol Action Ireland.

Implementation: All workshop trainers are QQI certified in Training, Delivery and Evaluation (Level 6) and have completed Training for Trainers (T4T) for each workshop. *Five Ways to Wellbeing Workshops* and *Webinars* are two hours and one hour in duration respectively, and offered to all staff with maximum online group sizes of 20 participants (for workshops) and 500 participants (for webinars). *Virtual Connect Café* sessions are 60 to 90 minutes in duration and offered free to all staff with a maximum recommendation of sixteen participants. Mental Health Ireland staff will sometimes host Virtual Connect Café's with workplaces, or will facilitate the workplace to host their own sessions. The *Mental Health and Wellbeing Managers* and *Employees Workshops* are each three hours in duration

and offered in online group settings to a maximum of 20 managers or employees, respectively.

Voluntary organisations also aimed to provide up-to-date resources and supports, to encourage the use of available frontline services, and to signpost additional resources. Many of the participating voluntary organisations are part of sector-niches and offer targeted supports to their specific populations, for example suicide prevention as well as LGBT support, youth services, support for those experiencing homelessness, encouraging men and young men to engage in their mental health, supports for the creative industry (mostly self-employed) and awareness of the effects of substance abuse on mental health. Voluntary organisations reported supports focused on skills or methods to reduce stress and enhance calm, including imparting a better understanding of mindfulness, the importance of practicing self-care and the use of creative arts as therapy to encourage calm and reduce stress.

It is important to note in the job-skills training category, that although staff are undergoing the training, it is not aimed at staff wellbeing for themselves, but rather to equip them with the skills to engage with and support vulnerable clients. Although their own mental health and wellbeing is not the primary target of these trainings, voluntary organisations reported that this staff jobs-skills training is personally valuable and initiates a conversation about mental health within the workplace that is beneficial to staff.

Table 3. Summary of intervention aims

Recognising mental health distress & supporting vulnerable individuals	**No. Reponses**
Crisis communication, providing support to somebody experiencing mental health problem (e.g., when employee discloses vulnerability) & supporting mental health distressed: understand, communicate & support (including signposting to additional resources)	12
Jobs-skills training: empowering staff to support vulnerable people; Fit-for-purpose suicide prevention training; building capacity of frontline service providers	6

Recognise mental ill-health; build skills & awareness of signs of suicide & self-harm (recognise, then tools to support them through difficulties)	4
Preventative: identify those who are experiencing mental health issues & need support & increase early help seeking (reduce stigma)	3
Skills to be supportive, approachable & communicate with LGBT & the importance of allies (awareness in those not in target groups so that they can be empathetic & champions to those that are)	2
Awareness & stigma reduction	**No. responses**
Raising awareness of mental health and wellbeing & reducing stigma of mental health in the workplace, creating empathy & awareness (LGBT)	10
Increase awareness: risk & protective factors of mental health (including awareness of social determinants of health & empowering staff to protect & sustain good mental health)	4
Accessing resources	**No. responses**
Support mental health (including signposting additional services)	11
Provide most up-to-date resources & promoting frontline services & supports (LGBT)	3
Sector-specific aims	**No. responses**
LGBT, youth, men & young men, creative industry, homelessness, Alcoholism (reflecting on how it affects their mental health)	8
Suicide prevention	5
Targeting workplace culture	**No. responses**
Positive mental health workplace culture, practices & openness (to feel comfortable to disclose); education: encouraging inclusiveness and acceptance & appropriate workplace interaction with colleagues; creating a safe space so people can be unafraid to voice questions (LGBT); Encouraging workplaces to create a MH policy (skills & resources) & make it a priority	10
Increase Awareness: Managers' protective role in supporting mentally healthy workplace	3
Stress resiliency	**No. responses**
Reducing stress or enhancing calm; promoting self-care; understanding mindfulness	8

Target Audience of Interventions

Themes in responses regarding target audiences were categorised and included non-targeted training, targeted training, job-skills training, unintended targets and additional characteristics. Specific responses are included in Appendix 3 (Table 3-e) and discussed below.

General training aimed at all individuals and staff within companies of all sizes was frequently reported, including staff and volunteers from other voluntary agencies. Trainings are also targeted toward more specific populations including mostly managers and senior decision-makers as well as youth workers and individuals in the creative industry who are typically self-employed. Additional training includes job-skills focused trainings targeted toward frontline staff or employees of health and social care services. These targeted employees include professional carers for older people, Human Resources or wellbeing staff and specific teams within the workplace.

Most participants within the target audience self-select to attend WPMHP supports and interventions. It is mostly unknown by the voluntary organisations whether incentives or accommodations are made by the workplace to facilitate staff engagement (e.g., protected time off or other flexible arrangements). Three voluntary organisations reported target-audience consultation during initial programme template development phases.

Interventions that are part of job-skills training sessions or interventions targeted to managers or senior decision makers were usually mandatory. Most supports are offered in a group setting. Individual coaching sessions were less commonly reported and included psychotherapy counselling services or mentorship programmes.

CASE STUDY: See Change in Your Workplace

See Change in Your Workplace is an organisational intervention developed in 2013. It was developed through intersectoral collaboration, partnership with IBEC and participation with service-users. The programme goal is to help facilitate a cultural shift in workplaces so that employers and employees feel supported and secure in starting a discussion about the effects of mental health. At the start of negotiations, programme coordinators The programme is reviewed and updated each year with additional refinements based on service-user feedback. An extensive evaluation of the programme occurred in 2018 where external researchers examined how the programme has been implemented, and compared the See Change project to international comparative programmes in order to offer recommendations to further align objectives with international best practice. The report highlighted noteworthy achievements including the care and integrity with which the programme was developed alongside reliable inter-sector partners, the programme's value as expressed by participants, the useful structure of the six steps in creating and embedding an open culture, the development of mental health policies by participating workplaces and increased staff training, and the engagement of staff and external stakeholders around mental health issues.

Intervention aim: The programme aims to promote overall organisational and individual wellbeing, enhance employee stress-management skills, and reduce costs associated with absenteeism, employee relations issues, and talent retention and acquisition.

Content: See Change is a six step pledge programme based on Social Impact Theory to help Irish workplaces create an open culture around mental health, play a role in challenging mental health stigma, and workplace environments where people can be positive about their own others' mental health. By signing up to the See Change workplace pledge, organisations show that they are committed to creating an open culture around mental health for managers and employees.

The programme includes workshops for senior leadership, HR and management, 1-hour stigma reduction workshops for general staff, and a champions programme that trains employees to be workplace wellness advocates. Programme

implementers strongly encourage workplaces to develop a mental health policy and offers the following resources to facilitate this endeavour: Action Plans and Mental Health Policy templates, IBEC line manager guides, case law review documents and other legislative guidance booklets, participant booklets, and additional downloadable and printable worksheets.

Implementation: The six steps of the programme are completed at an individualised pace in line with the workplace starting point and commitment. A formal commitment to the Pledge Programme is required prior to beginning implementation. The pledge includes minimum requirements for manager attendance, commitment to mental health related events throughout the year, a checklist that all components have been completed including policy implementation, and strong communication internally and with clients and other stakeholders about all efforts along the way.

Workshops are delivered by external facilitators in a group setting. Settings for delivery include in-person at workplace premises (minimum of 25 participants per session is required), online (minimum of 8 and maximum of 16 participants per session is required) and in hybrid format. Certificates of completion are offered to participants and an organisational certification is awarded on completion of the programme.

Setting and Duration of Interventions

Due to the COVID-19 pandemic, most interventions were recently translated from an in-person setting to remotely online (e.g., video-conferencing platforms such as Zoom and MS Teams, digital libraries, eLearning hubs or social media). Responses were overwhelmingly positive regarding the success of the switch, even citing some strong advantages to mental health and work-life balance. Prior to the pandemic, in-person interventions were held predominantly at client workplace premises or less commonly at the voluntary organisation's office or community or classroom settings or in hotels. Details are listed in Appendix 3 (Table 3-f) and discussed below.

Most workplace mental health promotion interventions were reported as two hours or under, between three and six hours, and one day, 10 hours or two days. There were additional characteristics noted about the intervention structure including sessions occurring as part of a series or sessions that include blocks tailored to different staff types (e.g., managers and staff are separated for a block of sessions). A tiered or staged approach was commonly reported, where skill-based training is built upon a foundation of awareness. Appendix 3 (Table 3-g) includes details of responses.

Planning of Interventions

Responses regarding planning of mental health supports and interventions were grouped into categories including minimal planning, programme-specific planning, non-specific planning and longer-term planning. Strategic planning approaches, including the use of planning or logic models, were not reported. Evidence-based needs assessment methods were reported, however these were unspecified.

Most voluntary organisations expressed minimal need for planning as most strategies include a universal content template that remains more-or-less constant with minor adjustments to adapt themes to workplace or target audience context. Additionally, systems, resources, materials and a panel of trained professionals are kept in place and then tailored to the occasion. Some supports are exempt from planning due to their real-time nature (e.g., counselling, helpline services, yoga classes etc.).

Non-specific planning includes general promotion of the voluntary organisation's message and services and of the WPMHP concept itself through public campaigns, social media and other awareness activities. Voluntary organisations also include the time spent building relationships with workplaces in non-specific planning efforts. Longer-term planning efforts of six months to one year were also reported. Details of responses are included in Appendix 3 (Table 3-h).

Quality Control Efforts for Intervention Content

Almost all voluntary organisations included some degree of consultation with academic literature. Typically, where evidence-based programmes were employed they were sourced from Canada, Australia or the UK. Experienced and qualified voluntary organisation staff interpret the academic literature to develop successful

strategies, use adult learning best practice guidelines and work across sectors to develop their interventions and strategic needs analyses. Programme piloting and consultation with target audiences or with other individuals with lived experience was less commonly reported. Voluntary organisations also rely upon credentialed specialists with experience in their field to implement their supports in-line with their profession's best practice standards (e.g., behavioural change and other theoretical models). Current research specific to at-risk populations guides voluntary organisation efforts to establish the need and rationale for increased support. Finally, the importance of anecdotal evidence from service-user feedback is valued and reported to engender trust within the sector and encourage referrals due to positive word-of-mouth. A listing of specific WPMHP supports and interventions offered by participating voluntary organisations is included in Table 4.

Implementation

Five voluntary organisations rely upon other agencies (n=2), external facilitators (n=1) or both (n=2) to implement their WPMHP efforts. Another four voluntary organisations implement their interventions or supports solely within their internal teams. The remaining nine voluntary organisations work internally along with additional supports from external facilitators (n=4), collaborations with other agencies (n=2) or both (n=3). External facilitators include credentialed professionals or trained volunteers or interns, while collaborating agencies consisted mostly of other organisations advocating for different niches within the voluntary sector.

Table 4. Examples of evidence-based programme templates and other quality control measures

Curriculum based on those found in the academic literature (particularly in Canada and Australia)
safeTALK Training and START programme (based on Canada Living Works)
ZSA Training (based on a UK programme)
Mental Health First Aid Training (based on an Australian programme)
Awareness Training for Managers (based on an Australian programme)
Suicide-specific Treatment Track Staff Training (evidence-based)

Engage: National Men's Health Training Programme (evidence-based)
Development of training based on academic literature in collaboration with staff expertise, consultation with service-user or 'lived experience' populations and according to adult learning best practice.
Responding to Mental Health Distress in the Community for An Garda Siochana Senior Managers Mental Health and Wellbeing Workshops Alcohol and Mental Health Workplace Mental Health Policy, Toolkit and Workshop
Training developed with external support across sector networks using academic literature and established needs assessment techniques in collaboration with service-users.
See Change in Your Workplace (Social Impact Theory) Safe and Supportive Schools Safe and Supportive Services
Training developed by qualified, experienced panel of credentialed specialists.
Exploring Self-care Using Creative Therapeutic Interventions Finding and Keeping Calm Employee Assistance Programme Counselling Counselling and Psychotherapy Services Mentorship Programmes Counselling or Wellness Apps Minding Your Mental Wellbeing Talks and Seminars
Need for support established in the literature; intervention curriculum is internally developed with staff expertise.

Creating LGBTI+ Supportive Workplaces LGBTI+ Awareness Training Champions Training
Training developed with staff expertise.
Know the Signs Listening Skills Workshop General Awareness Talks and Workshops Capacity Building Workshops eLearning Programmes Frontline services
Additional important quality control methods mentioned by participants.
Consulting evidence is important to see what works well, but anecdotal evidence from service-users also provides evidence of effectiveness on the ground. Initiatives developed through experience with workplaces and addressing commonalities in their needs.

Regarding resource acquisition, two voluntary organisations absorb the full cost of workplace supports within their overhead from fundraising, events, campaigns and the like. The remaining sixteen voluntary organisations rely on combinations of overhead (n=4); donations, grants or sponsorship (n=7); or as part of their statutory funding budget (n=8), with one voluntary organisation not answering the question. In six cases, the workplace supports are partially (n=5) or fully (n=2) self-funded. In the cases where workplace efforts are self-funded, it was reported that the workplaces themselves sometimes sponsor the service or, as in one case, the organisation has a health insurance service agreement in place to cover the cost. Additionally, national associations or bodies will help fund efforts.

Implementation Support

Workplace champions or committees emerged as extremely supportive as they act as gate-keepers and increase efficiency of communication with and commitment from workplaces, while enhancing enthusiasm, awareness and social support in staff. Additionally, workplace committees ensure employee participation in workplace wellness efforts and are also valuable in cases of employee turn-over (for example Human Resources or wellbeing staff), as the committee remains constant regardless of its members.

Voluntary organisations also reported efficiency in coupling strategies, combining their fundraising with workplace wellness awareness efforts or uniting Corporate Social Responsibility policies with employee wellbeing initiatives. In the latter, employees are supported directly, with additional indirect mental health benefits of being part of a company dedicated to the wellbeing of their community. The company benefits in efficiency by increasing outcomes through reduced efforts, and the voluntary organisation benefits mutually through continued interest and corporate support of their efforts. It was reported as being significantly helpful when workplaces had wellness policies or EAPs in place. Influenced by the COVID-19 pandemic, workplaces have recently demonstrated an increased appetite to learn more about their role in employee mental health and supporting those who express mental health difficulties. Objective analytics (such as service-user utilisation or number of counselling appointments made by employees) offer highly valued quantitative feedback to workplace decision-makers who use these metrics – as direct evidence of the value of their efforts – to create and adjust wellbeing policies.

Partnership with other sector-specific organisations or agencies, and particularly ones larger and perhaps more recognised, were reported as offering increased reach and improved capacity and expertise. From the standpoint of the voluntary organisation as well as the workplace itself, capacity was reported as an important supportive property. Workplaces that had more capacity in terms of finances, resources and venues as well as in terms of flexibility in scheduling programmes and employee work hours were particularly supportive. Voluntary organisations also reported that having more capacity within their own organisation facilitated implementation. Appendix 3 (Table 3-i) contains more detailed information on responses regarding supportive properties to implementation.

Barriers to Implementation

Voluntary organisations emphasised the essential need to cultivate trust and create a connection with the workplace in order to foster commitment and guide their culture. The time investment needed from both the voluntary organisation and the workplace to nurture this relationship becomes a challenge. These relationships can be enriched by establishing the relevancy of the voluntary organisation service within the workplace strategic plan or policy, which can create a further challenge. It was also reported that some workplaces might not fully understand the concept of WPMHP and might not be interested in offering supports within their working hours. Additionally, workplaces are typically reluctant to invest in more in-depth, time intensive strategies, and in assessing the extent of their commitment to WPMHP may choose to prioritise their investments differently. On the other hand, workplaces may have the commitment but not the capacity to engage in the necessary intensity of successful WPMHP strategies. Workplaces place emphasis on supports that are easy to access and avail of, which is also difficult considering the complex nature of WPMHP.

Other challenges to WPMHP efforts included a lack of facilitation by the workplace for staff to engage. Another challenge was associated with staff, particularly managers, who are obliged to attend interventions and may therefore feel less interested and less inclined to engage. Job stress can be a particular hardship for those with decision-making and leadership responsibilities and this can be compounded with additional responsibility to up-skill in recognising and supporting staff when they are experiencing stress.

It was frequently mentioned that there will be a large spike in WPMHP requests during an awareness month with a major tapering off during the rest of the year. While this heightened enthusiasm is appreciated by voluntary organisations, it results in two challenges. Firstly, voluntary organisations are unable to adequately facilitate the cluster of requests and secondly, this approach eludes the main concept of creating a year-round, omnipresent dedication to employee wellness.

The most commonly cited challenge was insufficient time and resources. Many voluntary organisations do not offer their workplace services as a main function of their organisation but rather as an additional service in response to a recent growing

need, and may feel inadequately equipped with capacity to meet it. Additionally, the loss of communication and quality of relationship due to workplace staff turnover (Human Resources or wellbeing representatives) can be challenging. Turnover within the voluntary organisation staff itself is also challenging, particularly in responding to the survey questions in this research where original development of interventions was often-times difficult to trace. There was mention of the incongruence of international interventions to the Irish context. For example, a Canadian-based intervention may include reference to resources that are unavailable to Irish citizens or segments of the content may not translate well into the Irish setting or culture.

Typical to any mental health promotion endeavour, general public awareness and persistent stigma is still a challenge; even more so when adding the workplace role. Promotion of their efforts within workplaces, and specifically to the appropriate decision-makers is particularly challenging for voluntary organisations. Conversely, with growing community and national campaigns and amended policies for mental health and at-risk populations, there is perhaps a tendency for workplaces to feel that these battles are already won and no further efforts are needed.

The inflexible nature of workplace schedules is a challenge to coordination and implementation of WPMHP strategies. Workplaces will sometimes dictate the allotment of time they have to spare, regardless of the amount of time required to sufficiently present material and content as part of an intently developed intervention. Furthermore, workplaces will sometimes change times or cancel at the last moment which can be an administrative and operational challenge to the voluntary organisation. Finally, irregular staff working times, as in the case of shift-workers or frontline staff, can be difficult to accommodate and can result in decreased attendance. Appendix 3 (Table 3-j) contains more detailed information on responses regarding barriers to implementation and Table 3-k contains more detailed information on responses regarding voluntary organisations' perceptions of workplace needs (which tended to match their activities since most of their efforts are in response to workplace requests).

Evaluation and Sustainability of Interventions

Most voluntary organisation evaluation efforts were focused on process evaluation. Participant feedback forms are completed after the WPMHP event in order for coordinators to see how their efforts were received, and sometimes followed up with an email or phone call to supervisors for further assessment. Additional information, such as an analysis of the profile of attendees, is gleaned from these feedback forms in order to profile participants.

Two organisations did not answer the question and a further two organisations responded that due to the informal nature of their efforts, no evaluation is undertaken. It was also reported that workplace efforts are in the beginning stages and evaluation strategies are forthcoming. Voluntary organisations reported that workplaces may record their own internal markers of their activities to promote employee wellbeing, such as absenteeism, productivity, morale etc. These types of organisational indicators (as opposed to those gained at the level of the individual) are not recorded by any voluntary organisation that participated in our study, although one organisation highlighted the need to convince workplaces to start measuring these organisational impact markers internally.

Impact evaluation was reported as being used to gain insights into knowledge retention and perceived usefulness of the programme. These include pre- and post-learning questionnaires, measurements of reach, engagement and service use before, during and after an event, and tracking of phoneline usage, enquiries, rate of download and user analytics of online materials or appointments made.

Formal evaluation was reported including action research by independent evaluators or, in one case, the intervention is part of a larger national initiative. Two organisations acknowledged that outcome evaluation is lacking and emphasised the importance of documenting more clearly the wider social impact of WPMHP efforts in order to demonstrate to workplaces the bigger picture of why promoting mental health in the workplace is worth the effort. One organisation pointed to ethical considerations of voluntary organisation evaluation of health outcomes that they do not have a remit to address. Details of responses are included in Appendix 3 (Table 3-I).

Voluntary organisations were asked about any efforts they have in place to make their initiatives sustainable within their client workplaces (i.e. ensuring impactful and lasting change within the workplace). Details of responses are included in Appendix 3 (Table 3-m) and are discussed below.

Encouraging committee or network formations within the workplace was reported as an effective way to embed a long-lasting supportive culture, as well as training staff as instructors that are embedded within the workplace to deliver their WPMHP in a peer-driven approach. Trainings sometimes become mandatory within the workplace (e.g., as part of new employee orientation). Voluntary organisations also reported that encouraging workplaces to couple their Corporate Social Responsibility efforts with their employee wellness efforts is effective at creating sustainable interwoven policies. Establishing a connection between the WPMHP training and workplace strategies was reported as helpful at embedding their efforts within the workplace.

The nature of some WPMHP supports were reported as leading to long-lasting and trusting relationships between the trainers and the workplace representatives, which can facilitate sustainability. Partnership-building across sectors helped to combine efforts for more effective and consistent reach and showed that relationships can lead to long-lasting, continuous change. Three organisations reported that they promote their WPMHP supports as part of a work plan or more integrated sequential strategy, and request a wellness policy to be in-place prior to initiating interventions rather than allowing once-off workshops. The very nature of these interventions is to create or enhance the workplace culture.

Summary

The overall findings from the mapping activity will be discussed here in relation to the what (programme components), where (setting), who (target audience and programme implementers) and how (implementation) of voluntary organisation intervention approaches.

What

Almost all organisations include anti-stigma and awareness-raising activities, with most declaring this as their main focus. Interventions to support vulnerable individuals and recognise mental health distress include a foundational awareness

piece to open additional topics. Many interventions are based on international programmes, including Engage (Australian-based male-focused programme), Mental Health First Aid, and suicide prevention trainings (Canada and UK-based programmes). Additional supports include skills to appropriately engage with vulnerable or at-risk populations and signpost to additional clinical and community services. The content of these more formal training sessions was reported as being fixed (e.g., contain non-negotiable implementation parameters), with minor adaptations to the workplace context and participants. When supports are general in nature, they are typically coupled with promotion of the voluntary organisation's message as these efforts serve the same purpose. These educational workshops and bespoke sessions are much more malleable, and workplaces have more control over the implementation of these more informal sessions (e.g., workplace dictates desired focus, participants and duration). While the use of evidence-based theoretical models was not specifically reported by voluntary organisations, these workshops are based on established adult learning strategies or developed in whole by experienced staff within the voluntary organisation, and needs and rationale are established in the academic literature.

Mindfulness or meditation-based interventions were less commonly reported. Supports focused specifically on depression and anxiety were rare and, apart from one case of psychotherapy counselling, the approach is general and educational in nature, centered around bringing awareness to the voluntary organisation's cause and establishing the rationale and importance of their work. In the case of psychotherapy services, voluntary organisations rely upon the professional standards of external facilitators to adhere to best practice (e.g., behavioural change and other theoretical models). Stress prevention interventions are surprisingly uncommon (n=3) with workshop aims reported to bring about awareness of the harmful nature of stress to mental health and overall wellbeing, and the importance of managing stress (e.g., resiliency and coping skills). There were no reports of addressing occupational stress specifically.

Interventions specifically targeting organisational structure as their main purpose are less common (n=3) as most supports are focused on individual employee support. It is important to note, however, that many voluntary organisations include manager-specific components or versions of their interventions and most acknowledged the

importance of organisational change, adopting an informal approach by way of building trust and relationships with workplaces and workplace champions to recommend strategies to support and encourage engagement of staff. Voluntary organisations perceived a challenge in convincing workplaces of the importance of flexibility to facilitate staff engagement. Organisational interventions were reported as focusing on increasing awareness of managers' protective role in supporting mentally healthy workplaces, encouraging and supporting workplaces to create mental health policies and making it a priority, and providing toolkits and resources for creating healthy workplaces. Additionally, interventions targeted workplace culture by encouraging inclusiveness, openness and acceptance, and creating safe spaces for staff to be unafraid to voice questions on sensitive topics or disclose mental health difficulties. Organisationally-targeted interventions were not reported as including a combined individual-targeted component (e.g., personal resource building), but did include signposting to external and community supports that focus on this area.

Digital interventions include eLearning libraries, mindfulness and meditation and one-to-one web- or app-based psychological counselling. Social media is also used in mindfulness supports including 60-minute yoga sessions. Other interventions include EAP counselling services, one-to-one and group mentorship sessions, and 60-minute creative therapeutic interventions to increase stress resiliency and enhance calm.

Where

Most WPMHP efforts are currently delivered online as either live interactions (video-conferencing, apps or social media) or pre-recorded digital libraries (podcasts, videos etc.) or resource hubs (toolkits, booklets, posters, infographics etc.). For the most part digital offerings include technical support or other options, such as phone or video calls, for service-user convenience. Voluntary organisations are delivering their WPMHP supports relatively evenly throughout the public and private sectors and predominantly to larger workplaces that have the capacity. When in-person, voluntary organisations will typically avail of workplace or community facilities and resources to implement their interventions with a small number of voluntary organisations having the capacity to hold interventions in-house. Most voluntary organisations have four to 50 employees with small implementation departments of

mostly under seven employees. Voluntary organisations also reported the help of interns or volunteers to implement their supports.

Who

Many workplaces engaging with voluntary organisations included banks, solicitors, retailers, multi-national corporations and other white-collar working environments, with less mention of male dominated professions and blue-collar workplaces. In one case, however, efforts are directed specifically toward men and young men. Reported target audiences include all staff, manager-specific, corporate operations decision-makers (Human Resources or other policy developers), self-employed, and, in the case of digital interventions, self-administered. Typically, supports are offered company-wide where employees self-select to attend. Little formal strategy is utilised to encourage workplaces to enable employees to participate, however, informal relationship-building allows voluntary organisations to offer recommendations in this regard. Where interventions are mandatory they are typically part of job-skills training sessions or interventions targeted to managers or senior decision makers.

Implementers are typically internal staff or external facilitators who are credentialed specialists or trained in delivery of a particular programme. Employees within the workplace itself are also trained to be facilitators in a train-the-trainer capacity. Approaches such as psychotherapy, counselling, mindfulness classes or creative therapy strategies are developed by qualified professional staff within the voluntary organisation, or through partnership with credentialed and experienced external facilitators.

How

Most supports are offered in a group setting. Individual coaching sessions were less commonly reported and include one-to-one psychotherapy counselling services or mentorship programmes. Mindfulness and meditation supports are mostly unstructured (provided on an as-needed basis as a single-component intervention) 60-minute group-based classes. Stress resilience trainings are universal (untargeted) 45- to 90-minute skills-based group workshops to create awareness and encourage micro-practices for stress management. Secondary prevention strategies for depression or anxiety supports included 50-minute one-to-one

counselling or psychotherapy sessions as well as signposting to additional community or clinical supports.

Organisation-level approaches are group-based and focus on supporting the culture rather than combined organisational and individual components. Three organisations reported consultation with target audiences at the development stage of their intervention templates, but no voluntary organisation reported employee involvement in policy or in selecting which initiatives are offered, although workplace committees were reported as an effective way to include participation from the bottom up while simultaneously ensuring long-lasting enthusiasm. There was no formal strategy reported to encourage workplaces to facilitate employee engagement, although building trusting relationships with decision-makers was reported as an informal practice to highlight the importance of enabling employees to attend interventions.

Anti-stigma or awareness-raising interventions are most commonly half-day, one-day or two-day multiple-component programmes based on international literature or developed with staff expertise with a tiered programme structure (e.g., a foundation on awareness, followed by personal skills building and/or recognising and supporting staff with mental health challenges). There were reports of formally targeted awareness supports that include elements of skills building, such as Alcohol and Mental Health, Minding Your Mental Wellbeing or Know the Signs workshops. More informal general awareness talks are typically single-component strategies and coupled with promotion of the voluntary organisation's cause. Some voluntary organisations also use role-play and experiential-based methods for participants to practice their skills interactively. General public campaigns or fundraising efforts were reported to permeate into workplaces and influence awareness and stigma (e.g., awareness campaigns or initiatives on specific awareness days or special times of year, such as World Mental Health Day or Christmas, have become popular and influence workplace social support).

Digital interventions include eLearning libraries, live group mindfulness and meditation classes, and live one-to-one, web- or app-based psychological counselling (the latter being targeted, not universal). Live offerings are in the form of video-conferencing and social media. Digital interventions are needs-based with unstructured schedules. Other interventions include one-to-one EAP counselling

services, one-to-one and group mentorship sessions, and group creative therapeutic interventions to increase stress resiliency and enhance calm.

Implementation is in almost all cases refined and improved according to feedback from participants and/or workplace coordinators. Less commonly, impact evaluation guides refinement of content in order to improve knowledge retention, engagement and usefulness of voluntary organisation supports. Rarer still are formal evaluations or outcome evaluations to measure broader and longer-term social impacts. There were no cases of evaluating workplace markers such as job satisfaction, staff morale, engagement, productivity or absenteeism, however it was reported that it is possible that workplaces may record these markers internally.

Conclusion

Voluntary organisations in Ireland are providing supports for mental health promotion and /or interventions in the workplace at either the individual level or the organisational level, in mostly online and digital settings. Individual-level interventions are typically aimed at increasing awareness and developing skills to appropriately interact with vulnerable individuals, and are built around a foundation of anti-stigma and awareness-raising. Less commonly reported individual-level support is aimed at promoting stress management or one-to-one psychotherapy counselling services or mentorship programmes. Organisational-level interventions are aimed at nurturing a mental health promoting workplace culture by enhancing manager skills and guiding workplaces to create policies and prioritising mental health promotion. Voluntary organisations informally guide workplaces toward evidence-based best practice (such as encouraging workplace champions and committees to enhance employee involvement; building relationships with workplace decision-makers to emphasise the importance of facilitating employee engagement in initiatives and policy decisions; and signposting to individual-level interventions in lieu of individual-components built into organisation-level interventions). Synthesising these mapping findings with those of the rapid review will provide guidance toward more formal and measurable strategies to ensuring employee engagement and toward more integrated approaches.

Chapter 4 - Integrating the Findings: Synthesis of Existing Workplace Mental Health Promotion Services and Rapid Review of International Evidence

The aim of this study was to map the range of mental health promotion supports and services that are offered by the voluntary sector to workplaces and to identify the most effective and feasible evidence-informed approaches that could be adopted to promote the mental health and wellbeing of workers in the Irish context. Twenty-seven voluntary organisations were identified as potentially providing mental health promotion supports to workplaces. Eighteen of these participated in the study, seven submitting an electronic survey, five participating in key informant interviews and six completing both. The rapid review of international evidence included systematic reviews, meta-analyses and second-order reviews of the effectiveness of workplace mental health promotion interventions published in the last ten years (2010-2021). Searches yielded 2770 articles, 43 of which were reviews included in the study. The findings from the mapping study and the rapid review were integrated to consider to what extent the approaches that are being delivered match international best practice, and to inform the recommendations outlined below.

The mapping study collected data from eighteen mental health voluntary organisations involved in the provision of support to workplaces. Voluntary organisations were typically small organisations (72% had under 50 employees), while the workplaces supported were more varied in size and sector. The supportive role of voluntary organisations is based on the cross-sectoral approach contained within *Connecting for Life*, the National Strategy to Reduce Suicide, (NOSP, 2015) and consistent with the National Healthy Workplaces Framework (forthcoming).

Voluntary organisations are in a unique position to provide support to workplaces, having expertise in mental health promotion, mental ill-health treatment and recovery and access to a range of materials and interventions to support good mental health. They are external to, and independent of, the workplaces they support. While this can be considered a strength it is also a weakness, as they are not empowered to mandate change in the culture, management style or policies and practices of a

workplace, all of which are important determinants of employee mental health or conversely, mental ill-health. Much of what voluntary organisations are requested to do is opportunistic, and this was reflected in the findings of the study.

A key finding from the study is that there was a wide variety of activities and supports provided, numbering 62 across the eighteen organisations. There was a clear commitment on the part of mental health voluntary organisations to work with workplaces to facilitate the promotion of mental health, yet at times their role and relationship constrained them in what was proffered, requested and accepted.

Anti-Stigma and Mental Health Awareness Raising

The types of interventions most frequently reported by the mental health voluntary organisations (just over half of interventions) were educational workshops and skill-trainings for appropriate interactions with vulnerable individuals, such as recognising mental health distress and signposting additional clinical interactions.

In the case of the former, educational events often aimed to bring awareness to the voluntary organisation's mission concerning mental health promotion, and were the main focus of engagement for voluntary organisations. These events occasionally included additional educational supports (e.g., 'coping strategies' or 'understanding mindfulness'), with the aim of influencing attitudes and behaviours through imparting knowledge. Almost all organisations provide anti-stigma and awareness-raising activities. Most activities were conducted in sessions/blocks that were of four hours duration or less. While the evidence-base for once-off mental health educational events generally is not strong (Laverack, 2014), the findings of the rapid review indicate the potential of these approaches. The evidence review demonstrates, somewhat cautiously based on the absence of RCT designs, that interventions to raise mental health awareness, increase help-seeking and reduce stigma do lead to improvements in mental health related knowledge, attitudes and in some cases, behaviours. Multicomponent anti-stigma interventions show potential in improving mental health-related knowledge, attitudes and behaviour in employees and managers, however, there is limited evidence on their impact on employee mental health and wellbeing. We would caution, therefore, against the expectation that anti-stigma education will result in mental health improvement for employees, or that once-off educational events alone will bring about change. We recommend that

awareness raising educational activities be framed as an entry point for voluntary organisations to facilitate engagement, with a view to on-going relationship building with workplaces and to steer workplaces toward more structured evidence-based approaches.

The rapid review found that most anti-stigma interventions consisted of multiple components, including mental health awareness raising among managers and/or employees, gatekeeper training, coping skills training, and wider organisational strategies to support employees with mental health challenges. This finding is consistent with the more general finding from reviews of organisational interventions that, in order to achieve positive work-related outcomes, individual mental health interventions need to be complemented by wider organisational strategies (LaMontagne et al., 2014). This suggests that voluntary organisations could utilize their entry point on stigma reduction and awareness raising to enhance their offering. Voluntary organisations could, for example, consider the Canadian Working Mind intervention (Castro et al., 2015) for which there is good evidence of effectiveness. The basic programme addresses issues related to stigma in the workplace, the use of a mental health continuum model to evaluate signs and indicators of mental disorder, and the development of coping skills. A manager version further addresses issues such as how to work with an employee who struggles with mental health issues, workplace accommodations, and overall management issues. This would sit well with the finding from the mapping study that voluntary organisations did, in some instances, provide manager–specific training. The rapid review reported moderate reductions in stigma and increased self-reported resilience and coping abilities consistently across settings and different target groups for this intervention, providing a strong argument for its introduction to Irish workplaces. Building on current initiatives, anti-stigma and awareness raising events be developed to incorporate a more multicomponent and integrated approach, for which there is convincing evidence of effectiveness.

The interest in skill-training for recognising mental health distress and for appropriate interactions with individuals experiencing mental health problems was in some cases in the form of supports for employees as part of their job, that is, job-skills required to engage with their typical clientele, rather than workplace support for the personal benefit and wellbeing of staff. This highlights the context in which voluntary

organisations are opportunistically engaging workplaces, and again could be exploited as an entry point for further work. The willingness to use these opportunities as entry points was evident in the case of one voluntary organisation, that offers a six-step pledge programme to help create an open culture and play a role in challenging mental health stigma.

Depression, Anxiety and Stress Prevention

Given the fact that occupational stress is a serious problem in contemporary workplaces, and likely to have been exacerbated by the impact of the COVID-19 pandemic in working life and on work-life balance, there was surprisingly few interventions in the mapping study that explicitly addressed stress. There was reference in the mapping study to once-off stress awareness sessions, but these did not appear to be focused on occupational stress, and concentrated on individual outcomes such as improved coping strategies. This is consistent with the finding that interventions specifically targeting organisational structure (which would be required to address the causes of work-related stress) were very uncommon with most supports addressing individual employee support. Where organisationally-targeted interventions were found in the mapping study, they were not reported as including a combined individual-targeted component (e.g., personal resource building), but did include signposting to external and community supports that focus on this issue, in order to avoid duplication of efforts in the sector. Yet the evidence review found that workplace interventions are most effective when organisational-level approaches are combined with work-related and personal resource building interventions in order to produce positive outcomes at both the organisational and individual level**.** Rather than sign posting personal resource interventions from other external agencies for workplaces, voluntary organisations could be supported to identify evidence-based integrated programmes which combine personal, individually-focused interventions with organisationally-focused approaches.

One organisation in the mapping study provided once-off unstructured yoga sessions on social media, and another incorporated education on micro-practices to manage stress, although otherwise there was very little evidence of stress management being a common call on or an offering from voluntary organisations. The evidence review findings indicate that there has been a surge in interest in mindfulness interventions, and that these interventions seemed to have the greatest level of

research evidence to support their effectiveness, demonstrating reduced stress and anxiety and improved wellbeing and work performance, with positive effects lasting up to 1-year follow-up. In this context, **we recommend that voluntary organisations consider adding mindfulness to their repertoire of offerings. Providing mindfulness and meditation-based interventions that have been demonstrated to be effective, could provide an opportunity to engage workplaces on the topic of stress and to engage them further on addressing the organisational drivers of stress.**

The apparently lower level of engagement on work-related stress interventions may reflect the difficulty voluntary organisations face in securing a foothold within workplaces around a topic that may be resisted on the grounds of concern that such interventions could target and change work practices and processes. However, the evidence for the causes of work-related stress points unambiguously to the work context as a key driver for stress (WHO, 2000) and this is an area that clearly needs to be addressed. Yet it was evident that voluntary organisations recognised the need for organisational change and addressing mental health promotion at the level of culture, and attempted to engage at this level. Intervention aims articulated the importance of creating a positive mental health culture, including policies and practices that encourage inclusiveness, openness, acceptance and appropriate workplace interactions. One organisation gave resources and guidance for policy change, in the hope of equipping workplaces with skills and resources to achieve this (including Action Plans, policy templates, legislative guidance etc.), although actual interventions were more limited in nature, and there was no formal strategy to engage employees in policy change. Voluntary organisations reported predominantly using approaches such as informal relationship-building and building trust with workplace champions to influence workplace culture. In establishing these relationships, voluntary organisations could advise workplaces on evidence-based strategies to support and encourage engagement of staff. **The relationship-building approach taken by voluntary organisations be supported to facilitate the implementation of combined individual and organisationally focused stress prevention strategies, for which there is greater evidence of effectiveness.**

With regard to workplace interventions for depression, the findings from the reviews indicate that CBT-based interventions, particularly when combined with other approaches and delivered universally, are a potentially effective way of preventing depression at the workplace. Most interventions using other therapeutic approaches, such as ACT and interpersonal therapy, were also shown to be effective, particularly those using a combination of different approaches. Yet the mapping study findings suggest that supports focused specifically on depression and anxiety are rare and the approach is general and educational in nature, centered around bringing awareness to the voluntary organisation's core mission and establishing the rationale and importance of their work. This is clearly an area that could be targeted for development. Although one-to-one counselling was identified as a support provided by one organisation, it would appear that voluntary organisations are not being asked to source or facilitate structured CBT or therapeutic-based interventions. It is clear from the rapid review that most of these CBT interventions are provided to workplaces by external agencies. Therefore, the voluntary organisations are well placed to source and promote structured evidence-based interventions to prevent and combat depression. **In order to better support mental health voluntary organisations in this regard, we recommend in the first instance, that a knowledge translation exercise be undertaken to increase awareness of the effectiveness of CBT and other therapeutic interventions in the workplace and the conditions under which these approaches are effective.** The possibility that workplaces are not seeking, or are resistant to, structured interventions to ameliorate or prevent depression needs to be investigated. **We, therefore, recommend undertaking a study to explore what barriers and facilitators may exist on the part of management with regard to the implementation of more structured evidence-based interventions for addressing depression and anxiety in the workplace. Further to these two activities, we recommend that a planned approach to implementing and evaluating depression and anxiety interventions be undertaken in partnership with voluntary organisations and clinical experts.**

Digital Interventions

Digital interventions were found in the evidence review to be effective in reducing levels of stress, anxiety and depression and improving wellbeing and work effectiveness, at least for highly educated white-collar workers, with less evidence of their effectiveness with blue collar workers. The current evidence on digital interventions indicate that most mental health and wellbeing interventions can also be delivered successfully online with support or as fully self-administered interventions. The evidence review also found that offering support, limiting the duration of the intervention, and using persuasive design technologies were associated with better engagement rates. The mapping study found heavy usage of digital technologies, with online being the most commonly reported setting, including interventions conducted live on video-conferencing platforms, use of digital libraries, eLearning hubs or social media. Given the timing of this study, it should be noted that all of the reviews of digital interventions were published pre-COVID-19, while the mapping study was conducted fifteen months into the COVID-19 pandemic, at a time when workplaces had switched many operations to digital and online modes of communication, with a proliferation of new software and tools for this purpose. The evidence that some digital interventions are effective is, therefore, encouraging, and indicates an opportunity for growth. Voluntary organisations could increase capacity by using online and self-administered interventions. **We recommend that a specific knowledge translation exercise be undertaken with voluntary organisations to identify and highlight the types of digital interventions that showed effectiveness (and those that have not) to maximise the potential for the use of digital interventions. Further, workshops on how to evaluate the use of such interventions could facilitate voluntary organisations to contribute to the evidence base in this area**.

Organisational and Work Engagement Interventions

Many of the voluntary organisations could be seen to be creative and resourceful in their methods of engaging workplaces. Voluntary organisations reported that workplace committees and champions are an effective way to encourage employee autonomy over workplace wellbeing initiatives. This way of working is a good example of employee participation and involvement. As noted in the review, effective implementation of organisational interventions requires employee involvement and engagement, managerial commitment, and integration into existing organisational systems. Voluntary organisations reported combining fundraising with workplace wellness awareness efforts, or coupling Corporate Social Responsibility policies with employee wellbeing initiatives, although there were few examples in the mapping study of initiatives to facilitate employee engagement. NICE and ENWHP guidelines recommend creating staff engagement forums with minutes recorded and resulting actions, such as policy change and commissioned wellness initiatives, transparent and well communicated to staff. **We recommend that practices such as working with workplace champions or committees, and coupling strategies, such as combining fundraising or CSR policies with employee wellbeing initiatives, be considered as a basis for facilitating employee engagement and to embed mental health policy in workplace strategic policy.**

Expanding the Reach of Current Workplaces

The mapping study revealed that many of the workplaces that voluntary organisations support are predominantly white collar; banks, solicitors, retailers, and multi-national corporations. With one exception, there was less mention of male dominated professions and blue-collar workplaces. This is mirrored in the review study, which found that the majority of intervention studies were conducted in the health care or educational setting or in large, white-collar enterprises, resulting in less evidence on the implementation of mental health interventions in SMEs or with blue-collar workers. However, promising evidence emerged from one review (Hogg et al., 2021), which explored depression prevention interventions implemented specifically in Small and Medium Enterprises (SMEs), many of which represented blue-collar, male dominated industries, such as construction, mining, metal forging and farming. Although methodological issues and high attrition rates were reported in many of the studies, findings indicated that CBT-based interventions can be an

effective way to prevent depression in SMEs. This encouraging finding suggests that if voluntary organisations can access SMEs and workplaces where blue collar workers predominate, there are interventions that have been shown to be effective in these settings. One organisation reported grouping their smaller workplace sites for efficiency in their own time and resources, while also facilitating increased engagement and diversity in attendees. This approach could be described and modelled for other voluntary organisations. **We recommend that voluntary organisations are supported to establish links with SMEs and workplaces where blue collar workers predominate, drawing on the types of interventions found to be effective in this review.** This will require identifying strategies for working with hard-to-reach groups, and could include promoting examples of successful engagement.

Conclusion

Workplace mental health promotion involves providing a continuum of interventions and supports for promoting the mental health and wellbeing of workers and creating a mentally healthy working environment. The findings of this study demonstrate that mental health voluntary organisations are committed to engaging workplaces and have provided a variety of activities and interventions to facilitate mental health in the workplace. This model of linking with voluntary organisations is therefore, valuable and should be retained. However, despite apparent commitment on the part of the voluntary providers, it is also evident that more needs to be done to attain a more comprehensive and integrated approach to implementing workplace mental health promotion as recommend by current guidance and available evidence. Integrated approaches are needed for workplace mental health promotion interventions to be successful, combining both individual- and organisational-level interventions that address the individual worker and the organisation as a whole. Supportive workplace policies and practices have a critical role to play in promoting mental health in the workplace, including reducing work-related stress and protecting the rights of workers experiencing mental health problems.

This study showed that while a wide variety of activities and supports are being offered by mental health voluntary organisations to Irish workplaces, the nature of what is delivered is somewhat constrained by the current model of service provision. The majority of the supports or services provided are demand-led and are therefore,

dependent on the willingness of workplaces to engage. This model restricts the type and range of services that are provided. The mapping study shows that the majority of services currently being provided are once-off educational and mental health awareness-raising approaches. The adoption of more structured, evidence-based approaches would enhance existing practice in the voluntary sector, especially with regard to addressing depression, anxiety and stress prevention at work. Current educational and awareness-raising interventions can act as entry points for engagement to develop trust and build relationships, with a view to introducing more structured organisationally-focused interventions. Stigma-reducing interventions, which, based on the findings from the review demonstrate the potential to improve knowledge and attitudes related to mental health problems, similarly could act as entry points for further engagement.

The implementation of such integrated approaches is, however, dependent on workplace engagement and managerial commitment so that ideally, they become an integral part of the organisational culture and management practices. These integrated approaches are critical to achieving more sustainable change and call for a longer-term process of engagement so that mental health promoting interventions are embedded in a more sustainable way within workplace policies and practices. This would require a shift in the current model of service provision.

The voluntary organisations are well positioned to support a strategic shift in approach by building on current initiatives and the positive relationships that have already been established with workplaces. Such a shift would also need to be supported by the current HSE funding model in order that more strategic planning for the delivery of structured longer-term strategies could be undertaken. This study suggests that there are examples of good practice that can be built upon and it would be worthwhile to provide a platform for bringing voluntary organisations together to share experience and good practice. This would also provide an opportunity to develop more focused knowledge exchange processes on how evidence-based approaches could be incorporated into the current model of service provision, especially with regard to the delivery of structured programmes for depression and anxiety, stress prevention interventions and organisational level approaches. There is an opportunity to expand the use of digital interventions, for which there is evidence of effectiveness, which could extend the reach of

interventions to a broader range of workplaces, including smaller workplaces and blue-collar worksites, which are underrepresented in the current provision arrangements.

That workplaces may not fully grasp the workplace mental health promotion concept was highlighted in this study and this needs to be addressed. This is evidenced by the focus on once-off events, the spike in requests to voluntary organisations on specific awareness days or special times of year, such as World Mental Health Day, and the use of mental health voluntary organisations to provide training rather than to support workers directly. Clearly, promoting a greater awareness of the scope and potential of workplace mental health promotion is required, rather than employing once-off workshops. The forthcoming National Healthy Workplace Framework may help in this regard, together with supports such as information, guidance documents and tailored resources for workplaces on best practice in promoting employee mental health and wellbeing. In particular, the possibility that depression is not well understood in the workplace setting could explain the lack of purchase on interventions in this area and points to a need for further research on attitudes to, and knowledge about, mental health disorders and a further need for information and guidance on depression and stress prevention interventions. A further potential would be to identify and explore case studies of successful engagement with workplaces that are characterised by a comprehensive and integrated approach to workplace mental health, including the implementation of organisational-level approaches, however complex and challenging, and their integration into workplace policies and practices.

Critical to informing the sustainability of current service provision and long-term planning on expanding the range of services is investing in evaluation. Systematic monitoring and evaluation of the process of implementing current workplace interventions and their effectiveness needs to be undertaken, including with regard to their cost-benefit. Supporting the evaluation of current initiatives would enable organisations and workplaces to document and demonstrate impact in terms of indicators of employee mental health and wellbeing, and also in terms of reduced stress, absenteeism, and improved productivity and job satisfaction. Developing an evidence base of effective practice and positive outcomes in the Irish context would strengthen the case for workplaces nationally to engage with services that will

promote the mental health and wellbeing of their employees. Training for mental health voluntary organisations could be considered in respect of seeking and evaluating evidence and providing basic skills or toolkits in evaluative methodologies to facilitate estimation of the impact of their interventions. Ideally, workplaces need to work in partnership with voluntary organisations to undertake robust evaluations of interventions.

The scope of this time-limited research project allowed a brief and general introduction to the workplace mental health promotion activities being undertaken within the voluntary sector. More in-depth research could afford organisations greater scope to explore opportunities and barriers for implementing more structured evidence-based approaches and how they could be integrated in a more sustainable way into the range of service provision and what supports would be needed to make this possible. The voluntary sector has a key role to play in advancing the implementation of current workplace wellness policies, including supporting the creation of supportive workplace cultures for improving mental health and wellbeing. Fostering partnerships among existing voluntary organisations and external agencies may be a way to enhance the range of service provision and increase capacity, thereby supporting the implementation of national frameworks and policies. Synchronising voluntary sector activities with national policies will further strengthen current efforts and capacity. With the implementation of the National Healthy Workplace Framework, there is a unique opportunity to combine Corporate Social Responsibility policies and employee wellness initiatives in order to create a more compelling case for workplaces and employees to engage with workplace mental health promotion initiatives and thereby ensure better health and wellbeing for their employees and greater efficiency for their organisations.

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Appendices

Appendix 1. Electronic Survey

[Introduction]

Thank you for participating in this survey. Your input plays an important role in progression of the Department of Health's Sharing the Vision policy, endorsed by the Healthy Workplace Framework. Additionally, your input guides the evolution of successful and efficient strategies to improve the implementation of mental health promotion interventions in the workplace. Please answer each question honestly and provide as much detail as possible. Click Next to begin the short survey.

NEXT

[Informed consent/participant info]

By submitting this survey, you are providing your consent to use your responses for the purpose of this research project, and are acknowledging receipt and understanding of the Participation Information Sheet.

I SUBMIT MY CONSENT

[Organisation demographics]

What do you consider the main focus of your organisation?

_____

NEXT

Approximately how many employees are employed within your organisation?

_____

NEXT

[Intervention info (who, what, where, how) & Evaluation info]

Which department within your organisation is typically responsible for implementing mental health promotion interventions to workplaces?

_____

NEXT

How many employees are within the implementation department identified in the previous question?

_____

NEXT

Would you say the employees in the implementation department work independently or do they rely upon additional support from other internal administrators?

_____

NEXT

Would you say your intervention approaches are typically focused on the individual or on the organisation/workplace?

- Individual-focused
- Organisation-focused
- Other (please provide detail): _____

NEXT

How are your interventions typically carried out (multiple options may be selected)?

- By internal programme coordinators only
- By external consultants
- In collaboration with other organisations or agencies

- Other (please provide detail): _____

NEXT

How do you usually obtain resources for implementation of your interventions (multiple options may be selected)?

- Internal resources are used as part of administrative overhead
- Resources are donated or sponsored
- Acquisition of resources is included in the funding budget
- Other (please provide detail): _____

NEXT

What are some of the most common barriers you encounter when implementing your interventions?

_____

NEXT

Are there any needs (mental health promotion-related or otherwise) that are consistently communicated to you by workplace organisations? In other words, what is your feel for the demand within workplace wellness?

_____

NEXT

What are some of the supports you receive that stand out as most helpful when implementing your interventions?

_____

NEXT

Regarding your typical clientele, do they belong to the Private or Public Sector

- Mostly in the Public Sector
- Mostly in the Private Sector
- Other (please provide detail): _____

Regarding your typical clientele, how large are the organisations you typically provide supports to?

- Less than 10 employees
- Between 11 and 50 employees
- Between 51 and 249 employees
- 250 Employees or more

Please complete the following table to provide details of your interventions. A list of definitions is included below to help explain the information requested within each column. There is a feature to print the list for ease of reference.

Column A – **Name of Intervention.**

Column B – **Type of Intervention.** Some examples of the type of intervention include: Educational packages, Workshops, Training, Advice or recommendations, Awareness events, Strategy building, Mental Health literacy, Structured programmes, Other programmes (mindfulness, meditation, relaxation etc.), Assistance in the evaluation of programmes, If other, please provide detail.

Column C – **Aim of Intervention.** Examples of aims: Promoting positive mental health and wellbeing, Reducing stress, Promoting work-life balance, Raising awareness of the importance of workplace mental health and wellbeing, Raising awareness of workplace bullying or harassment, Reducing stigma related to mental ill-health, Preventing common mental health problems (depression and anxiety) or suicide, If other, please provide detail

Column D – **Target Audience.** Your target audience would be the participants in your intervention.

Column E – **Intervention Setting.** Some examples of settings: In-house, On a virtual platform, At the workplace location of the client, At community centres or other public venues, At health

clinics or hospitals, At schools or training facilities, At hotels or other formal venues, If other, please provide detail

Column F – **Intervention Planning.** This includes how much planning your intervention required. In other words, what was the lead-in time prior to the start of the intervention? This would range from no planning at all to intensive strategic planning (timeline formulation, budgeting, resource allocation, evaluation considerations etc.).

Column G – **Duration of Intervention.** This refers to the length of time taken to carry out the actual intervention. Examples include: 1-hour Workshop, 2-Day Training event, 6-Week lifestyle intervention, 8-Class series, etc.

Column H – **Type of Evaluation.** Examples of evaluation types are included below:

Impact Evaluation: you evaluated whether or not you achieved specific targets/objectives, e.g., participant pre- and post- questionnaires to assess change in behaviour etc.

Outcomes Evaluation: you evaluated the long-term effects of your initiatives, e.g., participant three- and/or six-month post questionnaires to determine what changes might have occurred in quality of life etc.

Process Evaluation: you evaluated how well the initiative was implemented to inform program improvements e.g., questionnaires directed at either programme coordinators or participants about their experience during the intervention.

If other, please provide detail.

Column I – **Intervention Sustainability.** This refers to any efforts made by the programme coordinators to embed the programme within the workplace culture. Some details that might be helpful here include: Whether the intervention has been incorporated or influenced policies within the client organisation, Whether or not the intervention is repeated with the same clients on a regular basis, If you have repeat-clients that you've developed a rapport with, etc.

A	B	C	D	E	F	G	H	I

SUBMIT TO COMPLETE SURVEY

Thank you for completing this survey. You may be called upon to participate in a one-to-one virtual call to discuss your experiences in greater detail. The tone and quality of a one-to-one discussion offers a richer, clearer, more comprehensive understanding of your experience. Best wishes from the NUI Galway research team.

Appendix 2. Semi-structured Virtual Consultation Guideline & Prompting Points

Don't forget to mention that you will be recording

Briefly confirm the Organisation demographics

- Main organisation focus
- Number of employees
- Dept responsible for MHP Interventions & number of employees
- Are interventions carried out by internal coordinators or external consultants or collaborations
- How much additional admin support needed
- How are resources obtained (overhead, donated/sponsored, funding)

Briefly confirm the Client demographics

- Are clients Private or Public
- Are clients <10 employees, 11 - 50, 51 – 249, 250+

Get details on survey questions about Interventions/Supports

Would you say your intervention approaches are typically focused on the individual or on the organisation/workplace?

Do interventions offer any of the following; If not, does the client culture lend itself to these ideas:

- Is there any thought of promoting work-life balance, engagement, flexibility, work skills?
- What type of management commitment/engagement do you typically find? Are employees supported with flexibility/time/resources to implement interventions/education within their work day?
- What type of employee participation is there in deciding what problems to address and how? Is employee autonomy of concern?
- Get a sense of if the level of integration of approaches (are individual-based interventions backed by culture? Is implementation informed by employee expressed needs?)

Find out more about the Types of interventions.

Educational packages, Workshops, Training, Advice or recommendations, Awareness events, Strategy building, Mental Health literacy, Structured programmes, Assistance in the evaluation of programmes, Other programmes (mindfulness, meditation, relaxation etc.), Digital, Nature-based, Spiritual-based (self-compassion etc.)

- Are these interventions in a group setting or individual?
- Are they targeted to the individual or universal?
- Is there a one-to-one or group coaching element?
- If digital, is guidance provided? Is it app-based or computer-based?

Find out more about the Aims.

Promoting positive mental health and wellbeing, Reducing stress, Promoting work-life balance, Raising awareness of the importance of workplace mental health and wellbeing, Raising awareness of workplace bullying or harassment, Reducing stigma related to mental ill-health, Preventing common mental health problems (depression and anxiety) or suicide.

- Are approaches targeted at changing behaviours? Attitudes? Skills-building?

Find out more about the Target.

- Are they self-selecting to participate? What supports do they receive to engage?
- Is there a gender dominance in participants?
- Are targets managers or employees?
- Are there any supports for managers to handle a crisis?

Find out more about the Setting?

In-house, On a virtual platform, At the workplace location of the client, At community centres or other public venues, At health clinics or hospitals, At schools or training facilities, At hotels or other formal venues.

Find out more about the Planning.

- What was the lead-in time prior to the start of the intervention? This would range from no planning at all to intensive strategic planning (timeline formulation, budgeting, resource allocation, evaluation considerations etc.).
- Are strategies universal or tailored?

Find out more about the Duration.

- Are approaches tiered (first awareness, then skills, then behaviours etc.)?

Find out more about Sustainability.

- Has the intervention been incorporated or influenced policies within the client organisation?
- Is the intervention repeated on a regular basis with the same clients you've developed a rapport with?

Find out more about Evaluation.

- Impact, Outcomes, Process?
- How the intervention affected *individual* outcomes (mental/physical health, physiological biomarkers, job satisfaction, autonomy etc.)?
- How the intervention affected the *organisation* (cohesiveness/morale, culture, absenteeism, productivity, skills and service etc.)?

Find out more about barriers and problems they encounter.

- Do they ever feel they lack capacity (resources or supporting evidence) to offer supports?

Find out more about the demand from workplaces.

- What is your feel for perceptions of organisations of their role in MHP?
- Are most workplaces on-board or do you spend a great deal of time "selling" the concept of workplace MHP rather than focusing on the interventions themselves?
- How easy would it be to steer workplaces in the direction of the evidence (ie. integrated approaches that also focus on organisation culture)?

What are some of the supports you receive that stand out as most helpful when implementing your interventions?

Appendix 3. Data Collection Tables

Table 3-a. List of Voluntary Organisations providing Mental Health Promotion Supports to Workplaces in Ireland	
Participating organisations	
	Encapsulating their Focus
3T's	Suicide Prevention
Aware	Depression Support
BeLonG To	LGBT Support
Dublin Simon Community	Homelessness Support
First Fortnight	Mental Health Promotion
Helplink Mental Health	Mental Health Support
LGBT Ireland	LGBT Support
Men's Development Network	Males Support
Mental Health First Aid	Mental Health Recovery
Mental Health Ireland	Mental Health Promotion
Minding Creative Minds	Mental Health Promotion
MyMind	Mental Health Promotion
Ohana ZERO Suicide	Suicide Prevention
Pieta House	Suicide Prevention
Samaritans Ireland	Emotional Support
Shine	Mental Ill-health Support
Spunout ("Community Creations")	Youth Support
Suicide or Survive	Suicide Prevention

Organisations that did not participate but may provide mental health supports to workplaces in Ireland
Beacon of Light
Exchange House
National Family Resource Centre Mental Health Promotion
Grow
Northwest STOP
National Suicide Research Foundation
Self-Care for Carers
Turn2Me
USI

Table 3-b. Itemisation of responses regarding voluntary organisation main focus	
Support	**No. responses**
Support: Mental health	4
Support: Suicide	2
Support & improve lives of LGBT youth (advocacy, capacity building, training)	2
Support: Youth	2
Support: Depression	1
Support: Homelessness	1
Provide accessible & affordable mental health services & counselling for everyone in Ireland	1
Reduce suicidal behaviour leading to less deaths by suicide	1
Mental health recovery	1
EAP Services (including counselling/advice)	1
Provide resources for the creative industry	1
Education & training	**No. responses**
Education: Suicide awareness	4
Education: Mental health	3
Improve understanding: Mental health	1
Training to enable interaction/engagement with someone who may be experiencing a mental health problem	1
Training for LGBT community	1
Awareness & engagement	**No. responses**
Reduce stigma of mental health	3
Promotion: Mental Health	1
Prevention of Suicide and Self Harm	1
Awareness & Education: Suicide & mental health	1

Awareness: Suicide Prevention	1
Improve understanding: mental health	1
Awareness, Support, Training & Advocacy for LGBT	1
Engagement: Men & boys mental health, gender equality & healthy masculinities	1
Youth Information	1

Table 3-c. Itemisation of responses regarding types of interventions	
Interactive or skills-based	**No. Reponses**
Training (skills)	11
Role-play	3
Educational, interactive & experiential	2
Educational & interactive (Q&A's, group exercises)	1
Support services	**No. responses**
Advice (including policy/practice advice)	5
Online with technical support	3
Counselling services	3
Helpline	2
EAP counselling & support	1
Text message support	1
Apps with technical support	1
Peer support group/mentorship programme	1
Educational	**No. responses**
Workshops	13
Educational talks	2
Education: manage stress	1
Public awareness activities	**No. responses**
Campaigns, events, awareness, promotion etc.	5
Public awareness campaigns & special events to spread the work (e.g., Darkness to Light, Connect Café, television or radio appearances	2
Resources	**No. responses**
Resources (including videos)	2
Toolkits	2

Catalogue of booklets, brochures, posters, worksheets, packs, videos, podcasts, research	2

Table 3-d. Itemisation of responses regarding intervention aims	
Supporting vulnerable individuals	**No. Reponses**
Mental health distressed: understand, communicate & support (including signposting to additional resources)	5
Provide support to somebody experiencing mental health problem (e.g., when employee discloses vulnerability)	4
Crisis communication	3
Skills to be supportive, approachable & communicate with LGBT	1
Importance of allies (awareness in those not in target groups so that they can be empathetic & champions to those that are)	1
Awareness & stigma reduction	**No. responses**
Raising awareness of mental health & wellbeing	8
Reducing stigma of mental health in the workplace	2
Enhance understanding of mental health & social determinants of health in order to change approach to engaging with vulnerable people	1
Increase awareness: risk & protective factors of mental health	1
Support: empower staff to protect & sustain good mental health	1
Reduce stigma, create empathy & awareness (LGBT)	1
Accessing resources	**No. responses**
Support mental health (including signposting additional services)	11
Provide most up-to-date resources	2
Promote frontline services & supports (LGBT)	1
Sector-specific aims	**No. responses**
Suicide prevention	5
LGBT	2
Youth	2
Men & young men	1

Creative industry	1
Homelessness	1
Alcoholism (reflecting on how it affects their mental health)	1
Targeting workplace culture	**No. responses**
Positive mental health workplace culture, practices & openness (to feel comfortable to disclose)	4
Increase Awareness: Managers' protective role in supporting mentally healthy workplace	3
Education: encouraging inclusiveness & acceptance	2
Encourage workplaces to create MH policy & make it a priority	2
Appropriate workplace interaction with colleagues	1
Create safe space so people can be unafraid to voice questions (LGBT)	1
Stress resiliency	**No. responses**
Reducing stress or enhancing calm	4
Promoting self-care	3
Understanding mindfulness	1
Recognising mental health distress	**No. responses**
Recognise mental ill-health	3
Increase early help seeking (reduce stigma)	2
Build skills & awareness of signs of suicide & self-harm (recognise, then tools to support them through difficulties)	1
Preventative: catch those who are experiencing mental health issues & need support	1
Job-skills training	**No. responses**
Empowering staff to support vulnerable people	4
Fit-for-purpose suicide prevention training	1
Building capacity of frontline service providers	1

Table 3-e. Itemisation of responses regarding target audience of interventions	
Non-targeted trainings	**No. Reponses**
All staff	12
Individuals	11
Companies of any size	9
Other voluntary agencies	2
Volunteers	1
Additional characteristics	**No. responses**
Self-select to attend	8
Group setting (general)	5
Group setting with maximum participants	5
Group setting with minimum participants	3
Mandatory to attend	3
One-to-one coaching sessions (mentees or counselling services)	2
Targeted trainings	**No. responses**
Managers- & senior staff-specific	7
Self-employed	1
Creative industry	1
Youth workers	1
Job-skills trainings	**No. responses**
Frontline staff	4
Can include being required as part of skills needed in nature of job (e.g., Gardi, voluntary sector staff etc.)	3
Health & social care services/professional caring for elder people; wellbeing/HR staff; specific teams in workplace etc.	1
Unintended targets	**No. responses**

Secondary target (e.g., target is students, but teachers/staff benefit & work culture changes OR target is really for job skills, but participants benefit in their real lives too)	5
Secondary target (by-product of main focus: unintended consequences of supporting LGBT community: even more helpful for non-LGBT such as family members as they felt inadequate to support their LGBT family members	1

Table 3-f. Itemisation of responses regarding settings of interventions	
Remote	**No. Reponses**
Online platform: general	15
Online platform: Zoom	3
Online platform: MS Teams	1
In-house resources	**No. responses**
Organisation office (in-house)	6
Videos	3
Phonecalls	2
Online platform: Kara Connect	1
Apps	1
Other media: podcasts & print materials (booklets, packs, posters, brochures)	1
Client resources	**No. responses**
Company premises	9
Workplace intranet	1
Off-site	**No. responses**
Community or public centres	5
Education or classroom setting	4
Hotels	1

Table 3-g. Itemisation of responses regarding duration of interventions	
2 Hours or under	**No. Reponses**
90 minutes	8
60 minutes	7
2 hours	5
50 minutes	3
45 minutes	1
30 minutes	1
3 to 6 Hours	**No. responses**
3 to 3.5 hours	4
4 hours	2
6 hours	1
1 Day or over	**No. responses**
Available 24/7 (e.g., helplines or online catalogues of video trainings etc.)	2
2 Days	2
1 Day	1
10 Hours	1
Other characteristics	**No. responses**
Tiered/staged/layered approach to training	4
Sessions occur as part of series	2
Sessions have different blocks for different staff types	1

Table 3-h. Itemisation of responses regarding planning of interventions	
Minimal planning needed	**No. Reponses**
Panel of trained professionals	8
Universal training then made relevant/tailored to setting & audience	7
Content is fixed, therefore little planning needed	3
Resources, materials, trainers, systems & evaluation in place, then tailored to workplace context	2
Tailored template	2
Short Lead-in	2
Minimal	2
Planning not applicable (counselling, helpline, mindfulness services)	2
Programme-specific planning	**No. responses**
Included coordination with HR or workplace representative (to make arrangements or tailor content to specific goals/ team)	5
Involved partnership across the voluntary sector	5
Includes joint ventures with other organisations esp. with specific population (e.g., frontline workers etc.)	3
Will fast-track when needed (per workplace need)	3
Included Consultation with target audience	2
Included Piloting programme	1
Included extensive research, and resource & material creation	1
Part of larger National planning committee	1
Non-specific planning efforts	**No. responses**
Included promotion of services/ mental health in workplace concept	2
Includes general awareness efforts (social media work etc.)	1
Includes building relationships with workplaces	1
Longer-term planning	**No. responses**

6 Months	2
12 Months	2

Table 3-i. Itemisation of responses regarding general supportive properties	
Workplace champions or committees	**No. Reponses**
Employee with personal experience or interest (self/ family member/ friend) make great workplace champions	3
Dedicated person at workplace that supports wellbeing aspect of workplace (makes things efficient)	3
Workplace champion to facilitate proper buy-in & commitment & act as gatekeeper	3
Sympathetic Charity committee &/or champion	1
Networks/ groups within workplaces; champions/ peers ("tribe")	1
Staff team to push a message in the workplace and promote events	1
Charity committees to keep enthusiasm all year round instead of just one month/ one day	1
Champions can be valuable not only in facilitating WPMHP but can actually recognise signs of other staff who may need resources	1
Employee groups/ committees offer a sense of staff participation/ autonomy & input into workplace wellbeing efforts	1
Effective strategies	**No. responses**
Simultaneously promote mental health in workplaces by promoting their own organisation	4
By being open in the public (campaigns, fundraising, promotion, awareness) encourages public to be more open too	2
Combine Corporate Social Responsibility goals with employee wellness efforts (workplaces like to be seen to be working with VO as well as informing their staff of wellbeing supports)	2
Public campaigns, fundraising, promotion, awareness penetrates into workplaces (increasing engagement & them reaching out to invite VO into their workplace)	1
Systemic engagement in workplaces allows increased reach to cohort that wouldn't normally be reached	1
Feedback about service-users from frontline support services	1

The deeper (longer) & more consistent the training (ie sessions), the more it affects the workplace culture; one-off talks only do so much	1
Incorporating 'fun' ways to get message across & create level playing field between staff & head staff (ie. dinners/ parties)	1
Objective analytics (service-user utilization etc.) are highly valued by workplace as they can see directly the value (if ee's are using) & they use to adjust policy	1
Workplace commitment	**No. responses**
EAPs or other policies within workplace to refer staff to (policies in place)	4
Workplaces are clearly onboard with WPMHP concept as they're the ones reaching out to them by choice so really no barriers there	3
Managerial support (to show they're not just talking-the-talk, but walking-the-walk)	2
Management allowing time for staff to engage in interventions	1
Focus on managers to lead by example	1
Building capacity through partnership	**No. responses**
Partnering with bigger organisations or other sector organisations	2
Reliable, trained & experienced facilitators who take the VOs message & implement their programmes according to their ethos	2
Clients gained mostly through word-of-mouth and established sector networks & referrals (incl. HSE, social workers, other vol orgs etc.) therefore trust, anecdotal evidence & reputation within sector is important	2
Updates from NOSP	1
HSE & other research	1
Collaboration with other individuals or services	1
Peer support (VO is part of a hospital with support there)	1
Partnering with sector bodies (Irish Music Association, journalist bodies etc.)	1
Having more capacity	**No. responses**

Enthusiasm/ability of workplace to facilitate the VO: finances, times, rooms, engagement etc.	1
Workplaces having capacity/ wiggle room to offer supports to staff	1
VO having more capacity to provide more supports	1
Education	**No. responses**
Seminars & conferences & training	1

Table 3-j. Itemisation of responses regarding barriers to WPMHP efforts	
Workplace perceptions	**No. Reponses**
Would like to see more engagement from workplaces	2
Engaging with workplace & establishing relevancy of the service within their strategy/ policies etc.	2
Workplaces don't realise there's an issue (don't know what they don't know/ unconsciously biased or un-inclusive… not realising the complexity)	2
Sometimes managers are forced to attend (mandatory) & therefore aren't particularly enthusiastic (this can sometimes show in process evaluation forms)	2
Developing trust in workplaces	2
Creating connection with workplace	1
Investing time with workplace building relationship is essential	1
Workplace not understanding the nature of MH support (wouldn't allow posting helpline posters because didn't want to 'promote one charity over another' but posters should be for MH SUPPORT (not promoting charity)	1
Lack of flexibility in work expectations/ time off to attend initiatives (no facilitation to enable attendance) so productivity is still main concern rather than commitment to staff MH programmes	1
Lack of workplace knowledge/ interest in offering supports	1
Workplace motivations	**No. responses**
Workplaces jump in for a dedicated month (ie. Pride month/ heart awareness) but do little for the remainder of the year (Also, this week can become v. busy & unmanageable)	3
Reluctant to buy-in for longer/ time intensive interventions	2
Workplaces asses their use/investment of valuable time and might not feel it's important enough (so many just want quick talk rather than lengthy training)	1
Workplaces realise the importance (increased appetite) but actually then making changes is more challenging (lots of time persuading them to take action, not just realise)	1

Workplaces have fear-based approach ('open a can of worms' if staff engage in mental health programmes)	1
Motivation can come from not wanting to feel 'left behind' (ie extrinsic motivation for reputation of their business, but this is specific to trainings for front-facing roles that deal with the public instead of their own workforce benefit (ie for their job's benefit not their own)	1
Operational challenges	**No. responses**
Time and resources (increasing demand & not enough capacity)	4
Workplaces understand the importance of mental health, but might not have capacity to support	1
Turnover in HR/ wellbeing rep at workplace (lack of communication)	1
Adapting internationally-based intervention to the local context (service-users comment when resources/ videos are from other countries)	1
General awareness challenges	**No. responses**
Stigma: mental health & suicide	2
Access & ease of access to local services	2
Promotion of their work / advertising to the correct people	1
Perception that everything is fine now (ie after an Amendment is passed)	1
Target audience works primarily alone so getting the word out about services & creating awareness is difficult	1
Scheduling challenges	**No. responses**
Workplaces will dictate time (only have allotted time without regard for the intentions/ requirements of the intervention)	3
Scheduling programmes to suit specific times (shift-workers)	1
Frontline/ crises services (conflicts = attendance issues)	1
Timing/ Scheduling: workplaces aren't very flexible & change times at last minute	1

Table 3-k. Itemisation of responses regarding voluntary organisation perceptions of WPMHP needs	
Changing nature of workplace needs	**No. Reponses**
WPMHP not Main Focus but saw a need and responded (so no specific actions to promote culture/ org-focused/ sustainability measures)	5
COVID facilitated public awareness of mental health/ stress & engaged workplaces (recent increase in queries by workplaces)	4
Vol. Org is still evolving its workplace presence & strategies (just started including it in their remit as response to growing need)	3
There's recently been a feeling of low-level panic: feeling inadequate to deal with MH/ LGBT; realisation that things aren't changing & new approaches are needed to support the growing need	3
COVID (2019-2020) was busiest time	2
COVID resulted in more requests for counselling but less requests for workshops	1
COVID: Requests dipped in 2019 because workplaces were more focused on staying afloat and transitioning to remote.	1
Workplace need changes with societal context (ie. whatever is trending as an issue dictates the need, so it changes & thus is not preventative, it's more reaction to the societal narrative)	1
Short informational sessions	**No. responses**
Better understanding of mental health	2
Mental wellbeing talks	2
Coping skills programmes	2
Workforce burnout	2
COVID stress & affects	2
Stress overload	1
General wellbeing, managing stress	1
Lunchtime talks more than trainings (less time commitment)	1
Mindfulness techniques (meditation etc.)	1

'Soft' skills to use any time of day to improve stress levels & mental wellbeing	1
COVID has increased concern about loneliness/ isolation & workplace wellbeing	1
Short, direct course	1
Appropriate interactions with vulnerable individuals	**No. responses**
Reaction to an event (disclosure of vulnerability with no policy on how to handle)	2
Support employees in disclosing vulnerability (themselves or family members)	2
Responding to employees that disclose MH difficulties	2
The need for providing support systems to those with MH problems	1
Grief about incidents that have happened recently	1
Fear about potential crisis (risk aversion as the motivator)	1
Long-term absenteeism for mental health reasons	1
Skills to work with vulnerable clients	1
Creating accepting workplace environment	**No. responses**
Appetite to learn more about workplace role in mental health	3
Workplace interactions & valuing diversity in the workplace	2
Protected time & place to support engagement	1
Organisational support (flexibility: working times & remote working)	1
Creating an open work culture to communicate about mental health	1
Knowledge about EAPs & other external supports	1
Workplace policy compliance	**No. responses**
Used to feel like workplace is merely ticking box/ fulfilling obligations (ie. just one day [ie. pride month] instead of 24/7/365 culture) but seems more sincere now	4
Non-discrimination legal imperatives	1
Regular updates from HR	1

Specific sector support	No. responses
To learn more about correct language/ terminology (LGBT)	2
Self-employed can't afford private insurance so it's important for them to get these supports as well	1
Male-focused culture	1
Information about available supports	**No. responses**
Supports that are easy to use and staff can actually avail of	1
Supports that are easy to access	1

Table 3-l. Itemisation of responses regarding evaluation of interventions	
Process evaluation	**No. Reponses**
Participant feedback forms	9
Feedback form and phone call or email follow-up with workplace representatives	2
Feedback form that included attendee profile analysis	2
Process evaluation	1
None or not answered	**No. responses**
Workplace markers might be recorded internally (such as absenteeism, morale, productivity etc.) but not by VO"	7
None (informal awareness talks)	2
Not answered	2
VO still in beginning stages (evaluation strategies to come in the near future)	1
Impact evaluation	**No. responses**
Pre- and post- learning questionnaire (carefully organised for reference & to shape refinements)	1
Impact: knowledge retention, practicality/usefulness of programme	1
External agency to measure online & offline reach & understanding	1
Rate of download & use of online materials tracked	1
Online engagement/user analytics	1
Analytics of service-user utilization/appointments made	1
Carefully measured: reach, engagement, service use before, during & after event (phonelines, people coming forward etc.)	1
Other considerations	**No. responses**
Important to get workplaces to start measuring their own internal markers as well (easier to convince them when trust is strong)	2
Outcomes evaluation is lacking; need to get better at demonstrating social impact (big picture of why it's worth doing)	1

Physiological markers (psychological/ health markers) not appropriate as they are not clinically able to intervene (ethical considerations)	1
Formal evaluation	**No. responses**
Formal evaluation to include longer-term outcomes (option for workplaces to choose to be part of formal evaluation as well)	1
Action Research (independent evaluation)	1
Part of larger National programme evaluation	1
Outcome evaluation	**No. responses**
Health trends taken into account (Clinical governance & service delivery/ frontline resource use are closely tracked)	1
Outcome evaluation	1

Table 3-m. Itemisation of responses regarding sustainability of interventions	
Embed in workplace culture	**No. Reponses**
Nature of training is to shape culture	4
Establish Committee/ network within workplace	3
Training became mandatory	3
Couple fundraising & corporate social responsibility with employee wellness programme delivery (ie corporate sponsorship ticks both charity outreach box AND staff wellness policy for workplace)	2
Part of National programme (borne from Public Health Policy)	1
Training became part of a workplace strategy	1
Became part of new employee induction	1
Trained instructors embedded within workplaces to deliver trainings within their own workplace (peer-driven)	1
Recommend establishing staff committee that can keep enthusiasm all year instead of one month	1
Nature of workshops leads to relationship between trainers & workplace representatives	1
Companies will ask for advice/ signposting when developing policy (LGBT)	1
Building relationships or not answered	**No. responses**
Consistent, repeat client workplaces	6
Partnership building across sectors	5
Creating & maintaining relationship with the workplace	4
Continuous public awareness efforts	**No. responses**
Take advantage of awareness days (ie. World Mental Health Day etc.) or special times of year (Christmas etc.)	5
Consistent public awareness & fundraising measures	4
Continuous & strong online & offline presence promoting message	3

Popularity of a once-off initiative has kept it going (creation of a toolkit helped facilitate this)	1
Limited efforts or not answered	**No. responses**
Services provided in needs-based manner only (ie. not VOs main focus)	6
Not answered	2
Physiological markers (psychological/ health markers) not appropriate as they are not clinically able to intervene (ethical considerations)	1
None that we know of	1
Service is free therefore accessible	1
Training 'lifts the lid' so that staff feels open, engages more & able to build partnership (LGBT)	1
Need for additional services	**No. responses**
One-off workshops only as part of work PLAN or more integrated strategy	2
Consistent turnover of volunteers who need training	1
Refresher courses	1
Outcome evaluation	**No. responses**
Health trends taken into account (Clinical governance & service delivery/ frontline resource use are closely tracked)	1
Outcome evaluation	1

Appendix 4. Rapid Review Protocol

Population and setting

This review examined the evidence of mental health promotion and prevention interventions delivered in workplaces for adults.

Types of Interventions

The review focused on systematic reviews and meta-analyses on interventions aiming to promote mental health and wellbeing or prevent mental and behavioural problems in the workplace. Second order reviews of systematic reviews and meta-analyses were also included. Reviews were eligible for inclusion if they focus on interventions using individual or organisational approaches, aiming to:

1. Promote positive mental health and wellbeing or reduce stress using individual or organisational approaches
2. Raise awareness of the importance of workplace mental health and wellbeing and reduce stigma related to mental ill-health
3. Prevent common mental health problems (depression and anxiety)
4. Improve work engagement and work-life balance

Reviews of prevention interventions for people with mild to moderate symptoms of a mental health problem were included in the review. Systematic reviews and meta-analyses on treatment interventions for people with a diagnosed disorder were excluded. Reviews published in English between 2010 and 2021 are included in this review.

Outcomes of Interest

The outcomes of interest included:

- Mental health and wellbeing outcomes:
    - General mental wellbeing and life satisfaction
    - Mental health literacy and perceived stigma
    - Improvement in stress and stress management strategies
- Negative mental health outcomes:
    - Improvement in depression and anxiety related symptoms

Where available, information on the broader occupational outcomes such as productivity, work engagement and satisfaction, work morale, work-life balance, days absent from work, workplace bullying, workplace profile, improved work culture and organisational practices etc. will be provided. Possible adverse effects or harm are also reported.

Types of Evidence

Systematic reviews and meta-analyses of controlled and uncontrolled trials were included in the review. Second order reviews of systematic reviews and meta-analyses were also included.

Selection of Interventions with an Established Evidence Base

The findings from systematic reviews and meta-analysis were also used to identify the most effective intervention approaches that could be feasibly implemented in Ireland. Case studies of the most robust interventions were selected, with the aim of identifying characteristics of the most effective approaches. Implementation findings are reported as available in relation to the who (target audience and programme implementers), what (programme components), where (setting) and how (implementation) these interventions are delivered.

Search Strategy

Peer reviewed and grey literature were included in the review. The searched databases included:

1. Academic databases: PubMed, Scopus, ASSIA (Applied Social Sciences Index & Abstracts), Cochrane Database of Systematic Reviews
2. Public health databases: Evidence for Policy and Practice Information and Coordinating Centre (EPPI-Centre); National Institute of Clinical Excellence (NICE); BMJ Clinical Evidence; Databases of Abstracts of Reviews of Effectiveness (DARE)
3. National and international health and safety and occupational health websites: Health and Safety Authority (www.hsa.ie), BOHRF (British Occupational Health Research Foundation) (http://www.bohrf.org.uk/), Canadian Centre for Occupational Health and Safety (http://www.ccohs.ca/), European Agency for Health and Safety at Work (http://osha.europa.eu/), European Foundation for the Improvement of Living and Working Conditions (http://www.eurofound.europa.eu/), Finnish Institute of Occupational Health (http://www.ttl.fi/internet/english/), Health and Safety Executive (http://www.hse.gov.uk), International Commission on Occupational Health (http://www.icohweb.org/), National Institute of Occupational Safety and Health (NIOSH USA) (http://www.cdc.gov/niosh)

Additional sources include Google Scholar and reference lists for relevant articles, book chapters and reviews.

Grey literature (reports, conference papers, policy documents, dissertations and committee reports) were identified by:

- Searching Google using the search terms outlined in Table 1.
- Searching grey literature databases including: Zetoc, ETHOS, and ProQuest

Search terms

Systematic reviews and meta-analyses will be searched using combinations of the search words in Table 1.

Inclusion-Exclusion criteria

Systematic reviews and meta-analyses will be included in the review if they:

- Published from 2015 to 2021
- Published in English
- Include studies using controlled or uncontrolled study design
- Address the promotion of mental health and wellbeing (including work engagement and work-life balance) or the prevention of mental health and behavioural problems
- Are implemented in the workplace, including digital interventions

Studies are NOT included if they:

- Address the treatment of mental, emotional or behavioural problems.

Data Synthesis

For this review a narrative synthesis was undertaken. Given the review focuses on intervention effectiveness and questions concerned with implementation, a narrative synthesis is determined to be the most appropriate, as it offers more insight into potential confounders that are important in terms of programme replication and sustainability.

Table 4-a. Search terms for electronic databases

A **Positive mental health terms**	B **Negative mental health terms**	C **Type of intervention**	D **Population and setting terms**	F **Programme terms**	G **Study terms**
"Mental health" OR	Depression OR	Promoti* OR	Work* OR	Intervention OR	Systematic review OR
Wellbeing	Anxiety	Prevent*	Workplace	Education	Meta-analysis
Well-being	Stress	Universal	Employee	Program*	Effectiveness
"Well being"	Stigma	Indicated	Manager	Support	Implementation
"Life satisfaction"	Bullying	Targeted	Organisation*	Training	"Meta analysis"
Emotional			NGO	Therapy	
Psychological			Occupational	Effect*	
Psychosocial			Enterprise	Evaluation	
"Positive psychology"				impact	
Psychoeducation					
"Mental health literacy"					
"Work-life balance"					
Happiness					
Mindfulness					
Meditation					
Relaxation					

***** *denotes multiple word endings including singular and plural*

"" denotes only the full term will be searched for

Appendix 5. Rapid Review Table of Evidence

Table 5-a. Mindfulness/meditation interventions

Author Year of publication	**Type of review**	**Target group**	**Type of intervention**	**Studies included** **Type** **N** **Search year**	**Main outcome of interest** **Other outcomes of interest**	**Findings**	**Other**
Monzani et al., 2021	Second-order meta-analysis	Employees	Mindfulness	Meta-analyses N=13 2004-2020	Psychological wellbeing	Mindfulness-based interventions (MBI) had stronger effects on reducing negative emotions (g = −0.74)[1] than on increasing well-being (g = 0.58).	This study conducted a second-order meta-analysis on MBIs in the workplace. The study also tested a MBI against a MBI with character/strengths component. The MBI-strengths interventions had a stronger effect on wellbeing.
Pérez-Fuentes et al., 2020	Meta-analysis	Employees	Mindfulness	RCT, QE, pre-post N=24 2009-2019	Psychological health	Significant effect on mindfulness, anxiety, stress, negative affect and fatigue. Approaching significance for depression (p=0.06) and resilience (p=0.07).	
Vonderlin et al., 2020	Meta-analysis	Employees	Mindfulness	RCT N=56 <2018	Stress, mental health and well-being, job-satisfaction	Reductions in stress, burnout, mental distress, and somatic complaints, while improving mindfulness, well-being, compassion, and job	Heterogeneity among primary studies was not explained consistently by programme or participant characteristics in the exploratory moderator analyses. Results on work

[1] Cohen (1988) indicated that Cohen's d effect sizes of about 0.20, 0.5, and 0.8 are considered small, medium, and large, respectively. Likewise, Hedges' g of 0.15, 0.40, and 0.75 can be used as thresholds to interpret small, medium, and large effect sizes (Durlak, 2009).

						satisfaction—all with small to large effect sizes ranging from Hedge's g = 0.32 to 0.77. Results were maintained in follow-up assessments ≤ 12 weeks.	engagement and productivity were limited by low numbers of primary studies with outliers among their effect sizes.
Bartlett et al., 2019	Meta-analysis	Employees	Mindfulness	RCT N=23 studies, 1246 employees <2016	Stress Anxiety Depression Wellbeing Mindfulness Work performance	Beneficial effects following training for mindfulness (g = 0.45, p <.001) and stress (g = 0.56, p <.001), anxiety (g = 0.62, p <.001) and psychological distress (g = 0.69, p <.001), and for well-being (g = 0.46, p =.002) and sleep (g = 0.26, p =.003). Intervention effects maintained up to 12 months follow-up. No conclusions could be drawn from pooled data for burnout due to ambivalence in results, for depression due to publication bias, or for work performance due to insufficient data.	Heterogeneity in study designs and interventions reported.
Lomas et al., 2019	Meta-analysis	Employees	Mindfulness	RCT N=35	Wellbeing-related outcomes	Moderate effects on deficit-based outcomes such as stress	Quality of the studies was inconsistent, suggesting more

				<2016		(SMD = −0.57), anxiety (SMD = −0.57), distress (SMD = −0.56), depression (SMD = −0.48), and burnout (SMD = −0.36), and moderate to small effects on asset-based outcomes like health (SMD = 0.63), job performance (SMD = 0.43), compassion and empathy (SMD = 0.42), mindfulness (SMD = 0.39), and positive wellbeing (SMD = 0.36), while no effects were observed for emotional regulation.	high-quality randomised controlled trials are needed.
Slemp et al., 2019	Meta-analysis	Employees	Contemplative interventions	RCT, quasi-experimental, pre-post N=116 <2017	Psychological distress	Small to moderate significant effects on distress. Effects were moderated by the type of contemplative intervention offered and the type of control group utilised. General meditation-based interventions yielded the highest effects, followed by mindfulness-based interventions and ACT-based interventions	Types of interventions: mindfulness (55), ACT (13), meditation (14), combined (37) Evidence of publication bias, which is likely inflating estimated effects. Uncontrolled single-sample studies were more affected by bias than were large or RCT studies.

						showing the smallest effects.	
Heckenberg et al., 2018	Meta-analysis	Employees	Mindfulness	RCT, pre-post N=9 2003-2015	Physiological indicators of stress	Effective in reducing cortisol production, however, no changes were found for cortisol awakening response or concentrations for single a.m. and p.m. time-points. MBIs also improved autonomic balance, assessed by heart rate variability coherence measures, but not blood pressure. Sympathetic nervous system reactivity was also reduced following MBI. While aspects of immune function were also improved following MBIs, they were only assessed in a single study.	
Janssen et al., 2018	Systematic review	Employees	Mindfulness (MBSR, MBCT)	RCT, quasi-experimental N=23 (22 MBSR, 1 MBCT) <2015	Mental health	The strongest outcomes were reduced levels of emotional exhaustion (a dimension of burnout), stress, psychological distress, depression, anxiety, and occupational stress. Improvements were found in terms of mindfulness, personal accomplishment (a dimension of burnout), (occupational) self-	Of the 23 studies, 2 were of high methodological quality, 15 were of medium quality and 6 were of low quality.

						compassion, quality of sleep, and relaxation.	
Lomas et al., 2017	Systematic review	Employees	Mindfulness	RCT, QE, longitudinal N=153 (112 intervention studies, 48 RCTs) <2016	Mental health and well-being outcomes and performance	Mindfulness was generally associated with positive outcomes in relation to most measures.	The quality of the studies was inconsistent
Ravalier et al., 2016	Systematic review	Employees	Complementary therapies	RCT, QE, pre-post N=10 2000-2015	Stress and productivity	Mindfulness and meditation-based interventions were most effective in improving workplace health and work performance; the latter demonstrating some evidence of maintaining gains up to 3 months later. The evidence for relaxation interventions was inconclusive.	

Table 5-b. Psychological interventions for stress, depression and anxiety

Author Year of publication	**Type of review**	**Target group**	**Type of intervention**	**Studies included** **Type** **N** **Search year**	**Main outcome of interest** **Other outcomes of interest**	**Findings**	**Other**
Hogg et al., 2021	Systematic review	Small and medium enterprises	Psychosocial interventions	RCT, pre-post, quasi-experimental N=7 <2019	Depression, anxiety, suicidal ideation	Five studies showed a reduction in depression and anxiety symptoms using techniques based on cognitive behavioural therapy (CBT), two	Study quality was low to moderate according to the Quality Assessment Tool for Quantitative Studies. Low number and high heterogeneity of

						reported no significant change	interventions and outcomes, high attrition and lack of rigorous RCTs. Studies included 3 RCTS, 1 QE, 3 pre-post
Ihara et al., 2021	Systematic review	Employees	Group CBT	RCT N=10 <2019	Mental health and work performance	Eight studies showed that group CBT-based interventions improved aspects of mental health; ten studies demonstrated that group CBT-based interventions influenced some aspects of work performance-related factors. Overall, the reported effect sizes varied widely, from small to large.	
Bellón et al., 2019	Meta-analysis	Employees	Psychological and educational depression prevention interventions	RCTs N=3 studies <2018	Depression	Significant effects on preventing symptoms of depression with moderate effect size. OR 0.251 (95% CI 0.105–0.600, P=0.002)	Quality of evidence low Interventions based on social cognitive theory, CBT and ACT
Nigatu et al. 2019	Meta-analysis	Employees at risk of depression	Indicated prevention interventions	RCT N=16 2000-2017	Depression	Eight of 16 studies reported significant effects for workplace preventive interventions targeting depressive symptoms in which six were cognitive behavioural therapy (CBT)–based interventions and two were non–CBT-based interventions. Small to	

						medium effect sizes were found for both CBT- and non–CBT-based interventions (standardized mean difference= –0.44, 95% CI= –0.61, –0.26, I2=62.1% and standardized mean difference= –0.32, 95% CI= –0.59, –0.06, I2=58%, respectively).	
Wan Mohd Yunus et al., 2018	Systematic review	Employees	Universal and targeted Depression prevention	RCT N=22 (8 universal, 14 targeted) <2015	Depression	The cognitive behavioural therapy (CBT) approach is the most frequently used in the workplace, while interventions that combine different therapeutic approaches showed the most promising results. A universal intervention in the workplace that combines CBT and coping flexibility recorded the highest effect size (d=1.45 at 4 months' follow-up).	Interventions included: CBT, meditation/relaxation, combined Most interventions were delivered in group format and showed low attrition rates compared with other delivery formats. Although all studies reviewed were RCTs, the quality of reporting was low.
Maricuoiu et al., 2016	Meta-analysis	Employees	CBT, relaxation, skills development	RCT, quasi-experimental N= 47 <2014	Burnout related outcomes	Small overall effect sizes for general level of burnout (d = .22, p &1t; .05, k = 13) and exhaustion (d = .17, p &1t; .01, k = 34), and statistically not significant effects for	Cognitive-behavioural interventions and interventions based on relaxation techniques are effective only for reducing emotional exhaustion. New types of interventions are needed, to address

						depersonalization (d = .04, p > .05, k = 31) and personal accomplishment (d = -.02, p > .05, k = 29). Similar effects were also found at follow-up, suggesting modest but lasting effects of interventions in reducing burnout.	depersonalization and personal accomplishment. The analysis of intervention type suggested that three of four types of interventions have a statistically significant effect on exhaustion. The strongest effects were found in the case of interventions based on relaxation techniques (d = .51) and interventions aimed at improving role-related hard skills (d = .39), while the CBT-based interventions reported smaller effects (d = .15). Moderator analyses suggest that one reason why the effect size are so small is that most interventions included in the analysis were not specifically targeted (most of them were not specifically aimed at reducing the burnout level, but stress, and they were applied on a general population of employees, and not on those in need, with high level of burnout).
Tan et al., 2014	Meta-analysis	Employees	Universal depression prevention interventions	RCT N=9 1980-2013	Depression	An overall small positive effect on depression. CBT-based interventions, specifically, showed	The majority (5) of the included studies utilised CBT techniques, two focused on mental health literacy, one on physical activity and

						significant positive effects on depression.	one was a team-based participatory intervention. The CBT-based interventions used a range of related techniques.
Bhui et al., 2012	Second-order review	Employees	Individual and organisational interventions	Systematic reviews N= 23 (11 meta-analyses, 12 narrative reviews) 1990-2011	Depression, anxiety, absenteeism	Greater effect of individual interventions on individual outcomes. CBT showed larger effects than other approaches on individual outcomes. Organisational interventions showed mixed evidence of benefit. Organisational interventions for physical activity showed a reduction in absenteeism.	Some interventions led to a deterioration in mental health and absenteeism.
Dietrich et al., 2012	Systematic review	Employees with mild to moderate depression	Indicated/secondary depression prevention interventions	RCT, QE N=1 <2010	Depression	One intervention showed positive effects on remission and recovery up to 1 year after intervention.	Only one intervention study met the inclusion criteria (including diagnosis of depression). This evaluated the French APRAND intervention, combining diagnosis with psychoeducation.
Furlan et al., 2012	Systematic review	Employees with mild to moderate depression	Depression prevention interventions	RCT, QE N=12 <2010	Depression, sickness absence, work functioning	Evidence graded as very low on all outcomes of interest.	The authors were unable to recommend any of the identified interventions.

Table 5-c. Organisational interventions

Author Year of publication	**Type of review**	**Target group**	**Type of intervention**	**Studies included** **Type** **N** **Search year**	**Main outcome of interest** **Other outcomes of interest**	**Findings**	**Other**
Knight et al., 2019	Systematic review	Employees/or ganisations	Work engagement interventions (personal resource building, job resource building, leadership training, health promotion, mixed)	RCT, QE, pre-post N=40 <2019	Work engagement	Twenty (50%) studies observed a positive effect, two (5%) a negative effect and eighteen (45%) no effect. Intervention focus and delivery method, employee participation, manager support and intervention level (top-down vs. bottom-up) moderated outcomes. Job crafting and mindfulness interventions, bottom-up interventions were most effective.	Intervention focus: personal resource building (5), job resource building (12), leadership training (3), health promotion (18), job and personal resource building (2). Implementation difficulties were common, including high attrition rates and adverse factors, including organisational restructuring, redundancy and economic downturn.
Watson et al., 2018	Systematic review	Employees	Learning interventions	RCT, QE, pre-post N=41 2006-2016	Wellbeing Learning	Interventions focusing on developing personal resources for wellbeing are effective regardless of the specific focus of the training. Training focused on professional capabilities may have a positive effect on wellbeing and is unlikely to have a negative effect.	Personal resources interventions (n=22) Training for improving professional capacities (n=10) Leadership training (n=6) Interventions for enhancing organisational performance (n=3)

						Leadership training- inconsistent results, group-based interactive interventions may be more effective Organisational-level interventions – very low-quality evidence	Issues with implementation, uptake and organisational support reported in leadership and organisational interventions.
Knight et al., 2017	Meta-analysis	Employees/organisations	Work engagement interventions	RCT, QE N=20 <2017	Work engagement	Overall small positive effect (k=14, g=0.29, 95%-CI=0.12-0.46) on work engagement. Intervention type did not moderate outcomes. Mode of delivery had a significant moderating effect, with group interventions being more effective than interventions using other formats of delivery.	High heterogeneity between studies, and success of implementation varied.
Daniels, Gedikli, et al., 2017	Systematic review	Employees (advanced industrial countries)	Job design and employment practices	RCT, QE, Pre-post N=33 <2016	Wellbeing (burnout, stress, anxiety, depression, job satisfaction), performance	Well-being and performance may be improved by: training workers to improve their own jobs; training coupled with job redesign; and system wide approaches that simultaneously enhance job design and a range of other employment practices. Insufficient evidence to make any firm conclusions concerning the effects of training managers in job redesign and that	Successful implementation of interventions was associated with worker involvement and engagement with interventions, managerial commitment to interventions and integration of interventions with other organisational systems

						participatory approaches to improving job design have mixed effects.	
Daniels, Watson et al., 2017	Systematic review	Employees	Interventions to improve social environment	RCT, QE, Pre-post N=8 <2016	Wellbeing (mainly measured as job satisfaction), performance, social environment	Shared activities: Six out of the six studies demonstrated improvements in well-being across the sample (five studies), or for an identifiable sub-group (one study). Four out of the five studies demonstrated improvements in social environments, and four out of the five studies demonstrated improvements in indicators of performance. No effects for interventions targeting fairness perception.	6 interventions focused on introducing shared social activities, 2 improving fairness perception. Four of the shared activities did not employ a control group. The two interventions on fairness perception were RCTs. Analysis of implementation factors indicated that the interventions based on shared activities require some external facilitation, favourable worker attitudes prior to the intervention, and several different components.
Kröll et al., 2017	Meta-analysis	Employees/organisations	Flexible work arrangements and stress management training	RCT, QE, pre-post N=43 <2016	Psychological health, job satisfaction, job performance, absenteeism	FWAs and SMT are positively associated with psychological health and job satisfaction. Due to a lack of primary studies unable to analyse the effects on performance and absenteeism.	Large heterogeneity in the hypothesised relationships, additional moderator analyses of study quality, age, gender, duration and intention of intervention yielded no significant effects.
Ropponen et al., 2016	Systematic review	Employees	Organisational interventions	RCT, QE, longitudinal N=11 2000-2015	Work-life reconciliation	Effective employer actions focused on working time, care arrangements, and training for supervisors and employees.	Included interventions: the provision of employee parental benefits (paid parental leave etc.,) – two studies; job restructuring, working time arrangements,

						Flexibility, in terms of both working time and other arrangements provided for employees, and support from supervisors decreased work-family conflict, decreased stress, improved physical health and job satisfaction, and also reduced the number of absence days and turnover intentions.	and flexibility (part-time work, telework etc.) – two studies; organisational development or training activities (leadership training, diversity training, etc.) – seven studies. Initiatives for work-related resources (i.e., actions related to working time arrangements and dependent care) were influential within welfare states in Europe suggesting that beyond public child care, further actions to support work-life reconciliation are needed to support employees at work. Instead, the initiatives for personal resources (i.e., training of various types and target groups) showed efficacy in the countries without public health care and stronger social norms for longer working hours placing higher emphasis on fostering characteristics and abilities that enhance individual coping with the challenges of work life reconciliation.

Table 5-d. Digital interventions

Author Year of publication	**Type of review**	**Target group**	**Type of intervention**	**Studies included** **Type N**	**Main outcome of interest**	**Findings**	**Other**

				Search year	**Other outcomes of interest**		
Phillips et al., 2019	Meta-analysis	Employees	e-mental health	RCT N=34 <2017	Mental health	Moderate treatment effects on stress (Hedges'g=0.54), insomnia (g=0.70), and burnout (g=0.51) and small treatment effects on depression (g=0.30), anxiety (g=0.34), well-being (g=0.35), and mindfulness (g=0.42). The pooled effect on alcohol intake was small and nonsignificant.	The majority of interventions primarily addressed stress (18), ten studies addressed depression, seven addressed insomnia and mental well-being, five focused on reducing alcohol consumption, and two studies were dedicated to burnout reduction. More research is required to understand which factors contribute to the variation in effectiveness of particular interventions depending on the mental health area and characteristics of participants and interventions High attrition rates reported (>20%) The presence of guidance and higher quality studies were associated with significantly better outcomes. Problem-solving therapy showed significantly higher treatment effects for stress, depression, anxiety and burnout.
Carolan et al., 2017	Meta-analysis	Employees	Web-based psychological interventions	RCT N=21 2000-2016	Stress, depression, anxiety Work effectiveness	Statistically significant effect post intervention on both psychological well-being (g=0.37, 95% CI 0.23-0.50) and work	No statistically significant differences were found on either outcome between studies using cognitive behavioural therapy (CBT)

						effectiveness (g=0.25, 95% CI 0.09-0.41)	approaches compared with other psychological approaches, offering guidance compared with self-guidance, or recruiting from a targeted workplace population compared with a universal workplace population. Interventions that are delivered over a shorter time frame (6 to 7 weeks), utilize secondary modalities for delivering the interventions and engaging users (i.e., emails and text messages), and use elements of persuasive technology, may achieve greater engagement and adherence.
Stratton et al., 2017	Meta-analysis	Employees	eHealth	RCT, QE N=23 <2016	Depression, anxiety and stress symptoms	Overall small positive effect at both post intervention (g = 0.24, 95% CI 0.13 to 0.35) and follow up (g = 0.23, 95% CI 0.03 to 0.42). Differential short term effects between the intervention types whereby mindfulness based interventions (g = 0.60, 95% CI 0.34 to 0.85, n = 6) showed larger effects than the CBT based (g = 0.15, 95% CI 0.02 to 0.29, n = 11) and Stress	

						Management based (g = 0.17, 95%CI -0.01 to 0.34, n = 6) interventions. Stress management interventions differed by whether delivered to universal or targeted groups with a moderately large effect size at both post-intervention (g = 0.64, 95% CI 0.54 to 0.85) and follow-up (g = 0.69, 95% CI 0.06 to 1.33) in targeted groups, but no effect in unselected groups.	
Kuster et al., 2017	Systematic review	Employees	Digital vs. face-to-face stress management interventions	RCT N= 2 <2017	Stress, burnout	Very low-quality evidence with conflicting results, when comparing the effectiveness of computer-based stress management interventions with in-person stress management interventions in employees.	Workers were primarily white, Caucasian, middle-aged, and college-educated. Both studies delivered education about stress, its causes, and strategies to reduce stress (e.g., relaxation or mindfulness) via a computer in the computer-based arm, and via small group sessions in the in-person arm. Both studies measured stress using different scales at short-term follow-up only (less than one month). Due to considerable heterogeneity in the results, we could not pool the data, and we analysed the

							results of the studies separately.

Table 5-e. Stigma reduction and suicide prevention

Author Year of publication	**Type of review**	**Target group**	**Type of intervention**	**Studies included** **Type** **N** **Search year**	**Main outcome of interest** **Other outcomes of interest**	**Findings**	**Other**
Dobson et al., 2019	Meta-analysis	Employees (Canada)	Mental health and stigma reduction (The Working Mind)	Pre-post N=8 <2018	Stigma, self-reported resilience, and coping abilities	Moderate reductions in stigma and increased self-reported resilience and coping abilities.	The basic program addresses issues related to stigma in the workplace, the use of a mental health continuum model to evaluate signs and indicators of mental illness, and the development of coping skills. A manager version further addresses issues such as how to work with an employee who struggles with mental health issues, workplace accommodations, and overall management issues. Results consistent across settings and showed nonsignificant differences when various potential moderators of the program were evaluated (e.g., employees versus managers, public versus private sector, gender, age).
Gayed et al., 2018	Meta-analysis	Managers	Mental health training for managers	QE N=10	Mental health literacy, stigma, mental health	Significant effects on managers' mental health	An increase in collection of employee level data is required

				<2017	support, employee mental health	knowledge (SMD=0.73; 95% CI 0.43 to 1.03; p<0.001), non-stigmatising attitudes towards mental health (SMD=0.36; 95% CI 0.18 to 0.53; p<0.001) and improving behaviour in supporting employees experiencing mental health problems (SMD=0.59; 95% CI 0.14 to 1.03; p=0.01) No significant effects detected for the small number of studies evaluating psychological symptoms in employees (p=0.28).	
Hanisch et al., 2016	Systematic review		Stigma reduction	RCT, QE N=16	(1) Knowledge of mental disorders and their treatment and recognition of signs/symptoms of mental illness, (2) attitudes towards people with mental-health problems,	Anti-stigma interventions at the workplace can lead to improved employee knowledge and supportive behaviour towards people with mental-health problems. The effects of interventions on employees' attitudes	The quality of evidence varied across studies. Need for more rigorous, higher-quality evaluations conducted with more diverse samples of the working population.

					and (3) supportive behaviour	were mixed, but generally positive.	
Milner et al., 2014	Systematic review	Employees/Managers	Suicide prevention interventions	Pre-post, QE N=13 (5 evaluations) <2013	Suicidal behaviour, suicidal ideation, awareness, stigma and help-seeking	Three of the five evaluated interventions reported reductions in suicidal behaviour or ideation, that lasted up to 2-year follow-up. Two interventions reported significant increase in knowledge about risk factors, stigma and help-seeking.	Only five of the included studies had been evaluated, using a pre-post design

Table 5-f. Other interventions

Author Year of publication	**Type of review**	**Target group**	**Type of intervention**	**Studies included** **Type** **N** **Search year**	**Main outcome of interest** **Other outcomes of interest**	**Findings**	**Other**
Kotera & Van Gordon, 2021	Systematic review	Employees	Self-compassion training	RCT, QE N=10 <2020	Work-related well-being	Findings indicate that self-compassion training can improve self-compassion and other work-related well-being outcomes in working populations.	The methodological quality of these studies was medium. All ten studies recruited workers in a caring field and were mostly conducted in Western countries. There is need for greater methodological quality in work-related self-compassion intervention studies to advance understanding regarding the applications and limitations

							of this technique in work contexts.
De Diego-Cordero et al., 2021	Meta-analysis	Employees	Spiritual interventions (yoga, spiritual meditation, tai chi, religious activities, Reiki and Qigong, and spiritual workshops)	RCT N=6 2010-2020	General health, stress	Improvement of employee stress associated with spiritual interventions compared to no spiritual interventions at workplace (SMD, −2.31; 95% CI, −3.81, −0.80; p <.00001; I^2 = 97 %)	High heterogeneity and limited number of studies may hinder more robust conclusions
Sakuraya et al., 2020	Meta-analysis	Employees	Interventions for subjective wellbeing	RCT N=31 <2016	Subjective wellbeing	The pooled effect of included interventions on subjective wellbeing was significantly positive (SMD = 0.51; SE = 0.10). The pooled effects of mindfulness, CB-based approach, and other psychological interventions were significantly positive (p < 0.05). The effects of physical activity, environmental and multicomponent interventions were not significant (p = 0.10, 0.41, and 0.77, respectively).	Interventions categorised into: physical activity, ergonomics, psychological, environmental, multicomponent intervention, and others
Gritzka et al., 2020	Systematic review	Employees	Nature-based interventions	RCT, QE N=10	Mental health and wellbeing (mental health indices,	Consistently positive effects on mental health indices and cognitive ability, while mixed	Heterogeneity in interventions and high risk of bias in individual studies

				<2018	cognitive ability, recovery and restoration, work and life satisfaction, and psychophysiological indicators)	results were found for the other outcome categories.	
Joseph et al., 2018	Systematic review	Employees	Employee assistance programmes	QE, within group pre-post or post only N=17 2005-2016	Absenteeism, presenteeism, employee wellbeing	Improvements in levels of presenteeism and functioning. Mixed results regarding absenteeism.	7 pre-post, 5 post only, 5 QE Health and wellbeing and productivity outcomes not examined in most studies.
Vanhove et al., 2016	Meta-analysis	Employees	Resilience building interventions	RCT, QE, pre-post N=37 <2014	Well-being, psychological deficits, performance	Overall effect of programmes across outcomes was small (d = 0.21) and programme effects diminish over time Strongest effect on performance directly after the intervention, followed by wellbeing and psychological deficits. At follow-up, statistically significant effect found only for psychological deficits. Programmes employing a one-on-one delivery format (e.g., coaching) were most effective, followed by the	Interventions included one-to-one coaching/therapy, group programmes, computer-based programmes and train-the-trainer. Substantially stronger effects were observed among studies employing single-group within-participant designs, in comparison with studies utilizing between-participant designs. To optimize the effectiveness of resilience-building programmes, developers should carefully conduct needs assessments, identifying individuals at elevated risk

						classroom-based group delivery format. Programmes using train-the-trainer and computer-based delivery formats were least effective.	Methodological decisions (i.e., the use of within- vs. between-participant designs) may have a substantial impact on the conclusions researchers draw regarding the effectiveness of resilience-building programmes.
Robertson et al., 2015	Systematic review	Employees	Resilience training	RCT, QE, pre-post N=14 2003-2014	Resilience, mental health and subjective wellbeing, psychosocial outcomes, physical/biological outcomes, performance	Findings indicate that resilience training can improve personal resilience and is a useful means of improving mental health and subjective well-being in employees. Resilience training also has a number of wider benefits that include enhanced psychosocial functioning and improved performance.	Due to the lack of coherence in design and implementation, conclusions about the most effective content and format of resilience training could not be drawn. Interventions included: Penn Resilience programme (2), coaching (2), mindfulness/compassion practice (3), self-regulation of stress responses (2), CBT (5)
Theeboom et al., 2014	Meta-analysis	Employees	Coaching	RCT, QE, pre-post N=18 <2012	Performance/skills, wellbeing, coping, work attitudes, goal-directed self-regulation	Significant positive effects on all outcomes effect sizes ranging from medium g=0.43; coping) to large (g=0.74; goal-directed self-regulation)	