MENTAL HEALTH AND EMPLOYMENT

altogetherbetter

EVIDENCE REVIEW

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1.Introduction

This evidence summary looks at the evidence base for assessing the impact of interventions related to mental health and employment. It was commissioned as part of the evaluation of the Altogether Better programme, a five-year programme funded through the BIG Lottery, that aims to empower people across the Yorkshire and Humber region to lead healthier lives. The regional programme is made up of a learning network and 16 community and workplace projects which are working to increase physical activity, improve healthy eating and promote better mental health and well-being. Altogether Better has 4 projects focused on mental health and employment. These projects seek to improve health and well-being in workplace settings, with an emphasis on raising awareness of mental health issues through providing and targeting support, advice and training to employers and employees.

In 2009, the Centre for Health Promotion Research, Leeds Metropolitan University, was commissioned to evaluate the Altogether Better programme. One of the primary aims of the evaluation was to develop understanding of approaches to promoting mental health in workplace settings, linking to the existing evidence base. In this review a settings based approach is considered to be an approach which focuses on a particular location i.e. a workplace. It is worth noting however that there is a long and complex history of consideration of what a settings based approach might involve, taking account of different emphases and perspectives [1]. To develop an understanding of promotion of mental health in the workplace has involved a rapid review of evidence and the production of this evidence review. The evidence review is linked with a thematic evaluation of mental health and employment interventions in practice within the Altogether Better programme, and two further evidence reviews on:

- Empowerment & health and well-being
- Community health champions.

What is this review for?

This main purpose of this evidence review is to provide an overview of relevant evidence on interventions concerning mental health and employment. It has been written to help inform those commissioning, managing and supporting interventions in workplace settings around mental health.

The Altogether Better programme is based on an empowerment model which contains three strands: building capacity, building confidence and providing system change. This evidence review therefore explores how empowerment applies to mental health and employment and what processes facilitate empowerment in workplace settings. It presents findings in a logical sequence that first explains the types of intervention, how they work, before going on to summarise evidence of effectiveness. Findings are based on a rapid review covering the following aspects:

- definitions of mental health and well-being in relation to empowerment and employment
- key types and targets of interventions (what they are and where they are aimed)
- the processes or mechanisms by which a targeted intervention achieves outcomes (how they work)

- key outcome measures of the interventions (what is measured)
- evidence on the impact of interventions (to what extent do they work)
- comments of the strength of the evidence
- key issues for programme implementation.

The evidence review includes a brief description of the methods used in the rapid review and also highlights some of the issues for applying the evidence in practice. A short evidence summary is also available. A list of key terms is found in Appendix 1.

2. Methods

A rapid review of the evidence base around mental health and employment was carried out. This section briefly describes the approach adopted and the review methods that were used. The key objectives of this evidence review were to:

- undertake a review of existing evidence, both published academic work and grey literature
- provide an accessible synthesis of relevant evidence on definitions, processes and impact of the range of interventions related to Mental Health and Employment.

The evidence from different sources was selected and reviewed in a systematic way so that the results can used as a basis for developing practice, but it was not possible to undertake a full systematic review process in the time available. .

How was the review done?

A common approach and methods were used for all 3 evidence reviews (community health champions, empowerment and mental health & workplace interventions). This involved a series of stages from searching to review (see Box 1). A hierarchy of evidence was used to make sure that the strongest and most relevant evidence was reviewed. This meant that systematic reviews, reviews of published evidence and practice-based reviews, along with key conceptual papers and reports, were included. The search strategy and inclusion/exclusion criteria are found in Appendices 2 & 3.

In total 23 review papers were reviewed as part of the main mental health and employment evidence review (excluding those papers which were relevant to providing the background and context). A common analysis framework was developed across the three reviews. Findings from each selected publication were summarised using a data extraction framework (Appendix 4). These results were then brought together and written up for this evidence summary. A final stage involved the draft report being sent for peer review to academic and other experts.

Box 1: Stages of the rapid review process

1. Search strategy developed. This involved identifying key terms and synonyms, inclusion and exclusion criteria and agreeing relevant databases and web sites.
2. Searches conducted using major databases, including: MEDLINE, CINAHL, ASSIA, PsycLIT, The Cochrane Library and relevant websites such as Department of Health, NICE, King's Fund etc.
3. Screening to identify the most relevant papers and reports based on hierarchy of evidence and relevance to ATB programme.
4. Gaps in evidence identified and additional web searches conducted.
5. Development of data extraction forms and framework for synthesis of results.
6. Review of major papers, reports and other significant texts. Information extracted on key fields using a common data extraction framework.
7. Synthesis of findings in relation to types of intervention, processes, measures and outcomes.
8. Peer review of draft report and evidence based statements.

Limitations of the review

The evidence review was able to bring together a good number of research and practice-based review publications (23 documents included). There were some limitations with the rapid review process as the primary focus had to be on reviews rather than evaluations of single projects. This means that many studies and reports that may have very relevant information could not be included. Systematic reviews are considered to crucial to assessing what really works by carefully scrutinising the evidence from different research studies. However, the systematic review process can end up with a primary focus on quantitative outcome measures [2], which can mean that there is less understanding of how and why an intervention worked. We have tried to counter that limitation by including some practice-based reviews, using systematic criteria, see Appendix 3. Issues about translating this evidence into practice are discussed further in the final section of this report.

3. What do mental health and empowerment mean in a workplace setting?

Mental health has been defined in policy and research positively in terms of well-being. For example the World Health Organization states that '*Mental health can be conceptualized as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*' [3]. Current UK government policy defines mental well-being around '*ability to cope with life's problems and make the most of life's opportunities; it is about feeling good and functioning well as individuals and collectively…good mental health is the foundation for well-being*' [4, p.10].

Within that positive framework, which emphasises the potential for meaningful work to promote well-being, it is also recognised that a healthy workplace *environment* is critical in promoting well-being [4, p.48]. Current policy also places particular emphasis on the economic and social costs of unacceptable levels of **work-related stress**, as a trigger for lost working days and a factor underlying further illness in the workforce [5-8]. The contemporary view of stress is to consider it interactively in terms of a 'transaction' between the individual and the social environment [9].

The interaction between environmental stress factors and individual factors affects the well-being of people at work, where well-being is understood in terms of such aspects as individuals' ability to work productively and creatively, to engage in strong and positive relationships with others, fulfilment of personal and social goals, contribution to community, and sense of purpose [9].

> "*Stress does not reside solely in the individual nor in the environment, but in the transaction between the two. It is through the dynamics of this transaction that levels of wellbeing and stress are determined*." [9, p.14]

Among the many social influences on people's well-being in the workplace, are environmental factors concerning the wider economy and its impact on community and work, workplace organisation, culture, and circumstances, and individual age, socio-economic situation, ethnicity, culture, personal circumstances and personality factors. However, disentangling how these factors might affect stress and mental health at work, and specifically what might be the crucial additional factors contributing to risk, is quite challenging. For example, it has proved difficult to draw firm conclusions about gender, but factors such as multiple (family and work) roles, resulting in competing demands and less stable 'control' over the environment, have been suggested as significant [10].

How does research on mental health and employment relate to empowerment?

One area of interest for the evaluation is how the settings-based literature on mental health and employment fits with literature on empowerment, or if indeed it fits in any precise sense at all. The Altogether Better empowerment model contains three strands:

building capacity (awareness skills and knowledge), building confidence (self-esteem, social networks, internal confidence and aspirations of individuals and communities), and providing system change (collectively supporting a systematic change of culture in policy and practice). The model, when applied to work settings, would need to consider individual and organisational aspects, taking account of work-place structures, procedures and cultures, and take account of attitudes, capacity, and system change.

The research literature provides a number of approaches to power and empowerment at work. These approaches highlight workplace structures, processes and outcomes, and focus on organisational, cultural and individual levels. These different understandings are discussed below.

(1) The power of workplace structures and cultures. It has been suggested that understanding power at work means taking account of organisational/ structural, social, symbolic (this involves the use of cultural tools for making 'meanings' at work, such as the labelling of status through dress or office layout), and material dimensions of power, that can all affect workers' stress and health [11]. A structural approach to understanding empowerment at work has also been taken, for example by Edwards and Collinson [12], who suggest that to be empowered at work, employees need to obtain the following:

- broad objectives, not only predefined tasks (this affects people's 'control'),
- right of access to the means of achieving the objectives ('support'),
- enabled to make decisions on their own initiative ('decision latitude'),
- enabled to debate/challenge goals ('participatory power') [12].

The structural approach, highlighting organisational, social and symbolic/cultural meanings, has provided a basis for both primary (preventive) and secondary (targeted) interventions [11].

There has been a lack of conceptual consistency in the use of 'power' and 'empowerment' in mental health work, and tensions between the use of 'social/structural' and 'individual/consumerist' models have been identified [13]. It has been argued that to overcome limitations of both (structural and psychological/individual) approaches, it is also necessary to look at the hidden face of power. This hidden face involves the unspoken but understood ('tacit') ways in which roles and identities can be manipulated at work, for example showing someone in a bad light, or workplace 'bullying'. This approach has been advocated in relation to recovery approaches (which are very important for interventions with people who have been off work or out of work). This focus on hidden or unacknowledged meanings, for example concerning stigma and prejudice, implies that where mental well-being is an issue, there may be a need for [13]:

- *culture change* and alternative languages to challenge normalising/stigmatizing judgements,
- *structural change* to provide support in work settings and transfer of decision-making power,
- *positive relationships* for psychological empowerment.

(2) Empowerment as a process. The World Health Organization view empowerment as a process through which people gain greater control over decisions and actions affecting their health [14]. This definition has provided a basis for a more individual focused process strand of workplace empowerment research, which assumes that greater individual 'control' at work depends on self-directed processes for identification of problems, goal-setting, and development of methods and strategies to reach the

goals, as well as action for goal-fulfillment [15]. As for interventions with people who have been out of work, or absent from work with stress or mental health issues, process-based recovery models have been explicitly linked to empowerment and related ideas. Consumer definitions of recovery include hope, personal responsibility, self-defined goals, an end to discrimination, self-efficacy, advocacy and peer support [16].

However, settings-based work-place projects have encountered barriers to using empowerment as a core theme. Empowerment as a term is often considered outside the scope of workplace organisational change programmes. The issue of language has big implications for interventions which need to factor in considerations about workplace culture. Managers in many organisations (for example small businesses and large government organisations) may find the language of empowerment irrelevant, as it is too large and imprecise a term in relation to the constraints and drivers they operate under within their core remits. Such remits might include profit and turnover, and meeting business targets. These managers often view programmes in 'mundane' terms of fit with organisational remits and control, and appraisal systems and targets [12].

(3) Participation and self-help. Participatory action interventions are relevant to empowerment, but do not use empowerment language explicitly. Research exploring participatory action processes (PAR) has examined the idea that interventions involving changing group processes (as opposed to structures or individuals) can affect workplace culture [17]. This approach assumes that for health promotion interventions to have an impact they have to be ingrained in the culture of the organisation. Participatory action research actively engages stakeholders in project development across a series of stages, where results from one stage inform the development of the next. In a similar vein, self-help mutual aid groups and self management programmes run by mental health service users have been viewed as contributing to their own self-efficacy, which is a key to effective self-management of their mental health at work [18]. The self-help groups are viewed here as '*learning communities*' contributing to organisational knowledge. This approach involves employees and managers joining together in workshops to tackle workplace culture and develop well-being strategies. Support from employers is vital, as taking time out with work colleagues to discuss stressors is not part of legitimated work culture in many organisations [18]. Benefits from this approach around empowerment have been found at personal, inter-personal and collective levels [19].

One further possibility, that participatory interventions lead to empowerment was explored. For example, research found that groups of employees engaged in 'problem based learning' with a non-directive facilitator experienced 'reflection', 'awareness', 'self-direction' and other aspects which contribute to 'empowerment processes' such as 'gaining greater [psychological] control over decisions and actions' [15]. A risk of this kind of research is that the definition of the outcome (empowerment) may remain tied so closely to the process factors that there is a kind of circularity.

Overall the evidence on interventions concerning mental health and employment makes relatively little use of the term 'empowerment. Perhaps that is not surprising due to the ambiguities surrounding definitions of empowerment at work and the cultural and practical barriers to its use in workplace settings. The evidence review has sought to establish links to empowerment cautiously, where these seem justified from the use of key process or outcome definitions in the evidence such as 'self-esteem', and 'control', which are widely agreed to be relevant to empowerment. Where mental well-being at work is understood positively, as being about 'feeling good, and functioning well, as individuals and collectively' [4, p.10] such aspects as self-esteem and being in control

are likely to take on considerable importance. This will be explored further in the sections which follow.

4. What are the main types and targets of interventions?

This section briefly introduces the key types of interventions which are included in the evidence review. Interventions can be viewed as consisting of various dimensions, summarised in Table 1 below. These dimensions include:

- *type* of intervention: whether the intervention is primary (preventive), secondary (focused on at-risk groups still in employment), tertiary (recovery focused) or combinations of these;
- *target*: whether the target of the interventions is on organisations' structures or procedures, whether it is on individuals, or on group processes, or combinations of these;
- *focus*: whether the intervention is focused on processes, outcomes, or combinations of these;
- *problem*: whether the interventions focus on stress prevention and management, common mental health problems, severe mental health problems, or a mix of these.

Table 1. Dimensions of interventions

Intervention type	Target	Focus	Problem
• Primary • Secondary • Tertiary • Primary and secondary • Primary and secondary and tertiary	• Organisational • Individuals • Groups • Organisational/ • individual • Organisational/ • individual/group	• Process • Outcomes (individual) • Outcomes (organisational) • Outcomes (individual + organisational) • Process and outcome	• Stress prevention/ management • Common mental health problems • Severe mental health problems • Stress and common problems • Common and severe problems

The systematic reviews included in the rapid review covered a wide range of workplace health interventions, with considerable divergence across these four areas (above). For example there were secondary intervention types that focused on common mental health problems such as depression and anxiety, while there were also secondary interventions which focused on management of those at risk of or suffering from stress at work (which is not regarded diagnostically as a common mental health problem). The interventions had a shared focus on workplace settings, and a shared focus on mental well-being. However, the diversity means that measures of effectiveness, and any elements relevant to empowerment varies. In other words, the evidence needs to be carefully considered in terms of what works, how it works, for who, and in what contexts.

The divergence can be illustrated briefly by comparing systematic reviews. Concerning divergence by *type*, one review [20] was a systematic review of 24 studies on primary and secondary interventions regarding mental health issues in organisations. This review excludes tertiary interventions supporting those recovering from mental illness to return to work. Another review [21] focused on the impact of recovery orientated training and vocational interventions on non-vocational outcomes , such as self-esteem. This review focuses on tertiary interventions only.

Concerning the *target*, one review [22] focused on organisational interventions only, whereas another [23] incorporated a rating system which defined 'high rated' interventions as both organisationallly and individually focused, 'moderate rated' as organisational only, and 'low rated' as individual only. All of these were included in the review.

Concerning *focus*, the prevalence of experimental designs, such as RCTS, meant that there was little focus on process within many included studies [23-25]. Other studies include a process focus. For example Murta et al. [26] only include interventions with a process focus, while Egan et al. [27] includes only organisationally targeted interventions designed to increase employees' opportunities to make decisions or to participate in decision-making processes at work, and focuses on participation interventions.

Finally concerning divergence by *problem*, one review [25] focuses on 'common mental health problems', and includes 'prevention', 'retention' and 'rehabilitation' types of intervention (in other words, primary, secondary, and tertiary types). By contrast, Crowther [24] focuses on interventions for people with severe mental illness, and Waddell and Burton [28] include interventions around stress, around common mental health problems, and around severe mental illness.

Some understanding of the relationships between these dimensions or areas, as shown in Table 1, is important for developing a useful overview of the evidence. The 'problem or problems' addressed, and underlying concepts of the problem, are likely to influence the programme choice of type and target of interventions. If the 'problem' is workplace stress and its management, then psycho-social models such as Karasek's 'job demand-control-support' model (which states that individuals experience greater job strain when demand exceeds control) and Siegrist's effort-reward imbalance model (which emphasises reciprocity of exchange in working life, in other words getting a fair and equitable reward for effort) frequently provide a rationale for intervention designs. If the problem is severe mental illness, then a 'recovery' model with in-built 'stages' is sometimes preferred, which influences the intervention as it might for example need to be tailored around stages [21]. In turn, the type and target of the interventions is likely to influence the key 'roles'. Particularly, the choice of *individuals* as the target often leads to an emphasis on training or therapeutic practice [20, 24, 29], whereas choice of *organisations* as target might instead lead to a focus on participatory groups, or problem solving committees of employees [27], or supervisors or managers [22].

The variations around target, and focus (i.e. whether it focuses on process or outcomes), will also affect how the intervention stands in relation to empowerment. For example in the case of workplace stress interventions, relevant process factors are those which affect or 'moderate' the relationships between the workplace demand/control stressors experienced by workers and health or work outcomes [30]. These 'moderators' can

include 'support' dimensions, and employee 'participation' dimensions, which are also relevant to empowerment [23, 26, 31]. In the case of recovery oriented training/vocational interventions, relevant 'process' variables are focused peer support, and empowerment related factors such as 'breaking goals into manageable steps' and building self-confidence, trust and empathy [21]. The relevance of interventions to empowerment is usually not stated, but it can be inferred when these dimensions are present. This point about empowerment is developed further in later sections.

Combined and systems approaches

Building on the framework above, we now report in greater detail about the targets of interventions and the rationale provided. Interventions which provide some sort of combined approach (organisational and individual, or organisational and group and individual) have been described in various ways. For example, Murta et al. [26] reviewed 52 workplace stress management interventions incorporating process interventions, and distinguished between those which are organisationally focused, those which are combined, those which are individually focused, and those which involve an 'interface' (in other words they focus on person-environment fit). There is evidence that approaches which combined organisational and individual targets are effective [32]. Interventions which involved employer-employee partnership also demonstrated improved results compared with those which only focused on employee or employer [32].

Refining the ways of describing the targets of interventions further, Lamontagne et al. [23] distinguished targets at the 'interface' of organisations with workers (such as mechanisms for employee participation, or co-worker support groups), organisational targets (such as job redesign, or workload reduction), 'individual' worker targets (such as coping skills training, or employee assistance), and combined organisational and individual interventions. This review also connected up the analysis of intervention target with that of type. Interventions which combined primary and secondary or tertiary intervention aspects with feedback loops between these (so each is sensitive to developments in the others), and which highlight participation of targeted groups, and highlight context-sensitivity, were labelled **systems integrated approaches**. The study found that individually targeted low-systems-rated interventions were effective at the individual level, whereas organisationally targeted highly or medium level systems integrated approaches had favourable impacts at both individual and organisational level. It appears that organisational change in workplaces came about through environmentally/context sensitive combinations of

- combining targets (organisational and individual),
- participatory process, and
- systems integration of multi-modal interventions (preventive and secondary/tertiary).

Table 2 (adapted from Lamontagne et al. [23]) summarises options for systems integrated approaches with examples.

Table 2. Systems approach. [adapted from Lamontagne et al. [23]].

Intervention level	**Intervention targets**	**Examples**	**Systems integrated**
Primary • Preventive, proactive • Goal: reducing potential risk factors or altering stressor	• Stressors at their source; organisation of work; working conditions	• Job redesign, workload reduction, improved communication, conflict management, line manager training, skills development	Primary + secondary Primary + tertiary
Secondary • Ameliorative • Goal: help equip workers with knowledge, skills, and resources to cope with stressful situations	• Employee responses to stressors (perceived stress)	• Cognitive behavioural therapy, relaxation, coping skills training, anger management training	Secondary + tertiary Primary + secondary + tertiary
Tertiary • Reactive • Goal: to treat, support towards recovery, workers with enduring stress-related symptoms	• Short term and enduring adverse effects of job	• Return-to-work programmes, recovery support, occupational therapy, medical interventions	

Some reviews [21, 27, 33] additionally included a number of studies where the programme combined either individual and organisational target levels with a focus on group processes. For example, Egan et al. [27] included 11 multi-interventions studies, 4 of these involving participatory committees combined with individual level interventions that included training in stress reduction, relaxation and communication skills. Some inconclusive results raised questions about the conditions for effectiveness of participatory processes, specifically concerning organisational culture and support [27, 33].

A summary of stress intervention targets examples is provided in Table 3 (adapted from Giga et al. [29]). The individual-organisational area in this model addresses the meeting point between the individual and the organisation and takes account of role issues, work relationships, person-environment fit, and involvement in decisions. By contrast the *individual* level aims to address individuals' awareness of stress factors, and teach stress management or coping techniques, while the *organisational* level aims to modify the environment that may produce stress [29]. Interventions which target the individual organisational interface clearly encourage the key players to focus on processes. However, regardless of the target area, the intervening processes by which targeted

interventions achieve or fail to achieve outcomes remain of great interest (see also the following section).

Table 3. Target levels [adapted from Giga et al. [29]]

Individual target	Individual-organisational target	Organisational target
• Relaxation • Cognitive behavioural therapy • Exercise • Time management • Employee assistance	• Co-worker support groups • Participation and autonomy (through Participatory action groups)	• Physical and environmental • Communication • Job design

Targeting organisations or individuals?

A number of reviews examine organisationally targeted interventions by considering the psychosocial processes or mechanisms through which change is intended to occur [22, 30, 32, 34]. The term 'psychosocial' refers to a person's psychological development in an interaction with a social environment. Since most organisationally-targeted interventions nevertheless seek to measure individual outcomes, there is a need to understand what happens with individuals in terms of 'psychosocial' perceptions and affects (what they believe and feel) when structural/organisational change occurs, as a precondition of health or work outcomes further down the line [32]. Some reviews of organisational interventions addressed changing organisational practices that would affect people's perceptions [30] through:

- increasing employee control over work, around decision-making and work tasks, or
- improving the social support and communication around them [22, 32, 34].

Some reviews of *organisationally targeted* interventions examined the psychosocial effects of changes to objective structural aspects of work situations [30] for example to flexibility (in areas such as shifts) [22, 34]; others examined training of supervisors or line managers [22], and others examined interventions that seek to affect the work environment directly for example improving safety, space and comfort [30]. Some reviews also suggest that the effects of organisational change to the psychosocial work environment may be felt more by lower socio-economic groups and by men [34].

Further reviews examine interventions that target individuals through:

- training, on stress management (at primary and secondary levels) [20, 25, 26, 31, 32, 35],
- cognitive behavioural therapy (at primary, secondary and tertiary levels) [20, 32] and through supported employment [24, 25, 29],

- employment assistance programmes (EAPs) (at tertiary level) [36, 37].

Stress management interventions were further categorised for example by:

- health promotion interventions with a preventive emphasis
- communication and social skills;
- training to cope with stress;
- counselling and therapy;
- exercise and relaxation [20, 25].

Training individuals in (primary level) preventive stress management interventions was further broken down into elements such as practice learning, group discussion, and technique practice [31]. Cognitive behavioural therapy interventions (secondary level) could be combined for example with relaxation techniques, in what were called 'multi-modal' interventions, in reducing ill-health and absenteeism. This might occur through processes or mechanisms which could involve enhancing people's self-esteem, and reducing their anxiety about carrying out tasks [32]. Employee Assistance programmes (EAPs), a form of counselling in the workplace, involve professional assessment, referral and short-term counselling – for example over six sessions. However, EAPs have often been felt to ignore the workplace environment in their individual focus [37]. More environmentally-sensitive EAP approaches have been documented which include: commitment from managers, co-operation with unions, training supervisors, and a continuum of care with community agency involvement and follow-up [36]. Finally, supported employment interventions (tertiary level) place individual clients in competitive jobs without extended preparation, and involve on-job support from coaches or employment specialists [24].

In summary, this section has highlighted and provided illustration of the variety of targets of interventions concerning mental health and employment. We now turn to look at *how* the targeting of interventions is intended to affect outcomes for men and women at work, by focusing on the processes of the intervention.

5. What are the main processes involved?

It can be seen from Table 1 that the target area of an intervention may differ from the area where outcomes are measured. For example, the effectiveness of interventions targeted at organisational procedures may be, and usually is, measured at an individual level. It is therefore very important to try to understand the processes or mechanisms by which a targeted intervention achieves outcomes, since these processes are likely to involve significant 'intervening' variables or factors. Understandings at the process level may also contribute to valuable insights about empowerment. This can be seen in the individual-focused model set out in Table 4, which Edwards and Burnard discuss [38] (from Carson and Kuipers [39]), where process factors such as self-esteem and support networks and control are related to empowerment.

Table 4. Stress factors. Adapted from Edwards and Burnard [38]

External stressors	**Individual Process factors (moderators of stress)**	**Outcomes**
• Occupational stressors (work demands) • Major life events • Small stress 'hassles' or 'uplifts'	• Self-esteem • Social support networks • Resilience • Good coping skills • Control / mastery • Emotional stability • Physiological release mechanisms	• Positive stress outcomes – well-being, job satisfaction • Negative stress outcomes – ill health, burnout, low job satisfaction

This section describes how different types of interventions work and highlights some effective processes that can be mechanisms for achieving positive mental health and well-being outcomes.

Taking a systems approach

Some processes by which 'systems' approaches work involve combinations of prevention and early intervention, structural integration (for example linking occupational health and meeting core organisational business concerns), and participatory approaches. Some approaches were highly 'systemic' in type (i.e. they had primary prevention as a predominant approach *integrate*d with other secondary or tertiary intervention). They might involve, for example, job re-design, work pacing change, and improved support mechanisms. These approaches increased workers' perceptions of job control, which is a 'mediator' or a 'link in the chain' towards mental health improvement [23].

Tackling workplace stress at several levels (a 'multi-modal' approach) was considered more effective than single level 'unimodal' interventions. This might involve, for example, combining proactive preventive approaches focused at the organisational environment and secondary management approaches directed at individuals, such as training in behavioural techniques [38].

Engaging stakeholders

Participatory approaches made these interventions more systemic by providing feedback loops (between organisation and individuals for example), and were also likely to increase workers' perceptions of control, levels of support and their sense of justice. All these are 'moderator' dimensions of stress. Participatory approaches were also found likely to be accompanied by changes in organisational climate [23]. A combination of training and organisational approaches have been used to increase participation in decision making and increase support and feedback [32].

The demonstrated effectiveness of some participatory action research programmes in the workplace perhaps suggests that the ways in which decision-making takes place in the development of work-place stress management intervention strategies are as important as the strategies themselves. Involving employees and management together in needs assessment and strategy development is likely to increase workers' job control [29]. Participatory approaches also increase the likelihood of project sustainability through encouraging a culture of continuous improvement practice, and stimulating local ownership [23, 29]. Considering that stress in the workplace is affected by factors in the wider environment, it has been suggested that participatory interventions should expand the range of stakeholders to include, for example, family [20].

Organisational culture

Very important to the systems approaches, combining primary and secondary intervention, and including organisational targeting and participatory processes, is the assumption that where individuals' beliefs and perceptions are concerned, psychosocial factors like 'job control' can be influenced by affecting vital mediators, or links in the causal chain, such as the organisational climate or 'culture'. A single structural or environmental change, such as changing people's work schedules, does not necessarily influence workplace culture. Participatory interventions (such as those targeted at the organisational-individual interface – see Table 3) ran into problems within unfavourable organisational cultures. This happened, for example, where teams developed action plans but lacked support from site senior managers so that the interventions proved emotionally exhausting in the teeth of resistance [33]. New learning is then not translated into practice and this erodes people's confidence.

An aspect of a healthy organisation is employer-employee trust which can be engendered through successful co-participation of employees in planning and subsequent carrying through of programmes [41]. This therefore involves system change, and confidence and capacity building through a process of developing a culture of learning about mental health across organisations.

The review of stress at work conducted for the Work Foundation [40] found that, to control work-related stress:

- *individuals* need to be equipped with stress management techniques,
- *organisational changes* need to be directed at stressors
- *sources* of work stress located *in the culture and climate* of the organisation need to be addressed through creation of a 'healthy organisation' which takes responsibility for stress reduction, adopting a participatory, non-stigmatizing, communicatively open approach to do so.

Internal communication is an aspect of 'feedback loops'. Research on participative action approaches to work reorganisation found that improving internal communication, support and employee participation improves mental health – for example enabling managers or supervisors to speak with and listen to employees at an early stage [33]. Internal communication can be influenced by significant structural changes in organisations [31], for example making positive changes to workplace hierarchies [27].

Managing stress

A related aspect of organisational culture is the process of management support. Support from managers and supervisors has been identified as crucial to the success of stress management interventions and the more positive the participant perception of warmth and safe climate (i.e. above all else non-stigmatizing) the greater likelihood of affecting job-related stress [26, 32]. Peer support was very important in facilitating the success of both stress management and recovery-focused interventions [21, 32].

A key insight is that structural and/or cultural changes can affect individual outcomes through influencing intervening processes at a psychosocial individual level [34]. Structural changes which enhance employees' control over work [27] may have the greatest effect among manual workers and those from more deprived socio-economic groups for whom lack of control is more prevalent [34]. Also, structural change delivered through participatory processes can positively affect work-place culture, for example, contributing to a more trusting climate [41].

Such empowerment-related processes as self-esteem can be understood as vital psychosocial moderators between environmental stressors and individual mental health outcomes in a complex chain of causality. The stressors include high demands (workload, job complexity, intensity, pace) and low control/decision authority, while high levels of support protect against these [30]. The moderators or links between these stressors and outcomes for individuals can include sequences of effects or interactions between the stressors (how they work in combination), and the affective / emotional reactions of individuals [30]. These reactions might be affected through more enhanced participatory processes that can touch on the hidden (or tacit) dimensions of workplace culture, for example where greater support from management affects participant perception of warmth and safe climate [26].

Changing attitudes

A number of studies comment on the processes by which combined approaches involving organisational change and individual training might work. Stepwise, incremental change and top management/ leadership support might contribute to success [42, 43]. This might require taking account of the core objectives and culture of organisations, and of the importance of employers' and employees' attitudes and beliefs [32]. Participatory problem-solving approaches to organisational change, and cognitive behavioural approaches to individual training and counselling can both affect attitudes positively [32]. A key dimension that distinguishes cognitive behavioural approaches from other individual focused approaches such as relaxation techniques, is that it promotes the development of forward-looking, proactive rather than reactive responses to stress, which is one reason offered for its stronger effects [44]. This proactivity can also be encouraged through participatory organisational processes – assuming that they function in an empowering way.

The processes by which interventions work need to be environmentally sensitive in the broader, local, regional and national sense. The state of the economy substantially affects the organisational climate in which interventions take place and priority they are given [24]. The prevalence of mental health problems at work is also generally affected by social disadvantage, with greatly increased presentation in deprived communities, and influenced too by a range of non-work factors affecting individuals [25, 28]. All this reinforces the need for realism, concerning both the routes and scale of change. We now turn to look at how change has been measured.

6. What are the main outcome measures?

The majority of outcome measures reported at an **individual level**. A wide range of self-reported and objective outcomes included measures of:

- psycho-physiological health : somatic symptoms, measures of stress, job stress reduction and job satisfaction, mental health, wellbeing
- capacity and confidence: stress protective or coping factors, mental health literacy, skills, self-esteem, social capital and engagement, control, participation, and autonomy.

Studies were included which highlighted objective psycho-physiological and somatic complaints and physiological changes such as blood pressure, and cholesterol levels [23, 26]. Other studies used proxy measure of physical or psychological well-being around service use (GP visits), and individual sickness absence levels [34]. Other studies used measures of stress, with an emphasis on self-report, such as depersonalisation and emotional exhaustion [33], tiredness, fatigue and sleep [34], and anxiety and depression [29]. Well-being-focused outcomes were also used such as building 'mental health literacy' for overcoming barriers to help-seeking [42]; work-life balance, and time spent with family [34]. Outcomes focused on skills were also included such as stress management and coping skills [22, 23, 42], time management, and ability to problem solve [31]. Measures of job stress and job satisfaction were also combined to take account of positive and negative affect together [26].

Psychosocial measures of control and participation at work were used in interventions involving setting up participatory committees [27], and psychosocial measures of autonomy and participation were included in interventions aimed to improve decision-making [30].

Studies which measure various psychosocial outcomes have also demonstrated associations between them and mental health outcomes. For example cross-sectional studies have shown associations between various psychosocial characteristics of work (job satisfaction, demand/control, effort-reward, social support), and subjective measures of health and mental well-being; while longitudinal studies have shown support for causal relationships between demand/control and mental health over time [28].

A number of studies used measures around individuals' self-esteem, quality of life, social capital and engagement. These measures were used in tertiary interventions focused on recovery [21]. Other measures used in tertiary interventions around supported employment included obtaining and/or retaining competitive employment over lengths of time ranging from 3-18 months [24, 25, 28].

A smaller number of reviews also identified studies with **organisational outcomes**. Organisational measures may however require a longer timescale to collect [43]. The most frequent of these organisational measures for stress management or stress or workplace mental health prevention interventions was *absenteeism* [20, 25, 26, 30, 32]. Those studies which involved a predominantly primary preventive approach, while also combining this with other secondary or tertiary preventive methods, were also found to be effective for reducing absenteeism [23]. It was far rarer for secondary interventions

focused on early intervention with those with common mental health problems e.g. depression and anxiety at work, to use organisational outcomes like absenteeism [25]. Job retention/turnover, working conditions [23, 31], and improved productivity [29] were other, less frequently used organisational measures of the effectiveness of stress management interventions.

The shortage of studies since the 1990s which included **cost effectiveness** or cost benefit measures was noted [22]. However, economic modelling produced projections that work-site interventions can reduce absenteeism and presenteeism costs, and this supports the business case for interventions [22]. Among the very few reviews including measures of cost effectiveness, studies which involved a predominantly primary preventive approach while combining this with other secondary or tertiary preventive were also found to be more cost effective than others [23]. Some, by no means all, employment assistance programmes were found to be cost effective, but the research designs here were not consistently robust [36, 37]. Studies on Individual Placement and Support schemes for people recovering from severe mental illness have highlighted that they are not necessarily expensive, but the economic benefits remain unproven [25].

7. What difference do workplace health interventions make to health and well-being?

The above sections have highlighted the variety of interventions and the challenge of drawing brief conclusions about what works best. This section now pulls together the evidence from the reviews on the impact of the interventions and which type of approaches are most effective.

Changes to work organisation which increase workers' control and which increase the proportion of support available in relation to the psycho-social demands of work can have important benefits to workers' health and may reduce health inequalities. This is particularly likely to be the case when the interventions involve worker participation in their implementation [27, 34]. Multi-modal or combined target approaches which include both organisational and individual levels of intervention appear to work well and offer more prospect of sustainability than single target approaches [25, 29, 31, 40]. This applies in particular where these combined, 'multi-modal' approaches are also participatory, for example involving co-worker support groups and mechanisms for employer-employee participation [20, 23]. The process by which interventions at the organisational level work to affect individuals' mental well-being by reducing stressors involves various intervening factors, and can be quite complex [30].

Approaches which are called 'highly systemic' have been found to work better than less systemic approaches. The use of 'systemic' is not consistent across the reviews. Common elements across reviews include that the systemic interventions combine primarily preventive organisational approaches with some focus on secondary and/or tertiary intervention [23, 42] and they include feedback loops linking up information between the different levels [20], for example through participatory processes involving employer-employee partnership [32]. Greater involvement of line managers and supervisors contributes to better outcomes [26]. Participatory approaches within organisational or organisational-and-individual combined interventions can affect workplace culture or organisational climate in empowering ways, and assist in making change sustainable [29, 41].

Individual or organisational/individual interventions which focus on individuals' beliefs and attitudes and not just on work conditions are more likely to be effective [32]. Interventions which have several aspects at an individual level, for example focusing on personal support, social skills, and coping skills training, are more likely to be effective for those at some risk, than those which are less multi-facetted [25]. Individual interventions that focus on cognitive behavioural techniques have been found widely effective for people with common mental health problems [25]. These interventions produce stronger proactive effects than alternatives such as relaxation, but on the other hand they are more lengthy to deliver and demanding to act on, so they may be less popular in some settings [44]. Individual level psychosocial interventions such as training can have limited effectiveness without the organisational support of senior managers [33]; their greater support leads to better implementation and improved outcomes [26].

Return-to-work interventions offering supported employment have been found to be more effective than prevocational training in helping people with severe mental illness to

obtain competitive employment [24]. Among the key aspects of interventions which contribute to recovery for people who have experienced mental illness are:

- the importance of identifying peoples' strengths
- encouraging self-confidence, trust, hope and empathy
- appropriate timing of experiences of work,
- effective and timely support

These are also aspects which can contribute to empowerment [21].

Finally there is a need for more high quality research designs, for example longitudinal studies which can give rise to better understandings of how the different parts of interventions connect up, highlighting causal relationships, workplace culture, and individual change. The next section provides further discussion about the robustness of the evidence base.

8. What is the strength of the evidence?

This section briefly assesses the strength of the evidence base for reaching the above conclusions, and highlights the main research gaps. The great majority of studies included were systematic reviews and the inclusion criteria were rigorous, employing evidence hierarchies for selection, however, some design problems with the original studies were highlighted in the reviews. Issues included: small sample sizes [38], the relative short span of most interventions which lessens the opportunity for gauging impact of organisational structural and cultural change [29], and not taking account of concerns about disclosure of mental health issues: in other words missing the great importance of workplace culture in particular around stigma [31].

Although the purpose of the reviews varied across the dimensions highlighted in Table 1, there was overall a narrowness in the range of the interventions represented. The majority of studies were primarily targeted at individuals rather than organisations [32, 42]. There was a relative lack of evidence concerning processes or mechanisms by which outcomes were achieved [21, 23-26]. There is therefore a need for interventions to be designed in a multi-facetted way. This means targeting organisations and individuals, combining prevention and early intervention, exploring the process factors by which workplace stressors can be changed or managed [22, 30], and examining interactions between the individual and their environment [28].

The context for settings-based work-place research is wider than the setting itself; for example in times of recession participatory interventions become more challenging [27], particularly in more vulnerable organisations such as small businesses where managing directors may question their value and purpose. So there is a need for wider context-sensitivity in designing and evaluating interventions. This means taking account of the effects of unemployment and social gradients in health and regional deprivation as aspects of the interaction between the person and the work environment [28].

Concerns have been raised that many individual studies are conceptually weak, lacking consistency in the terms and definitions they use, and also mixing together subjective and objective measures without clarifying the issues [22, 24, 30, 31], however, the reviews included in this report make up for that with considerable conceptual emphasis. Many primary studies have been carried out outside the UK, which raises questions about their relevance [31]. Overall, the evidence base on outcomes is stronger than that on process, and the design of studies does not easily enable important questions to be asked about the interaction between different factors and the sustainability of particular approaches.

How do we build an evidence base?

The evaluation of Altogether Better, through the learning network and the four workplace projects, offers a good opportunity to improve understanding of some of the practicalities of developing empowerment approaches in different workplace settings. While the evidence reviews have commented on the relative lack of process evaluation compared with outcome evaluation, it is also highlighted that most valuable evaluation work needs to focus on examining the relationships between processes and outcomes [22, 26]. So it remains very important in programme implementation and evaluation to

explore evidence of what works, under what circumstances, and how well the different components fit together in particular contexts.

The findings of this review suggest that local evaluations need to:

- look at what works best, for whom and under what circumstances and how the different parts of the project work together
- be explicit about what empowerment means in the project and how it can be measured
- explore what factors facilitate or inhibit positive changes
- try to capture some organisational outcomes as well as outcomes for individual beneficiaries
- examine the longer term impacts, particularly on organisational structure and culture.
- consider the cost effectiveness of workplace mental health interventions.

9. What does this mean for practice?

This final section highlights some implications about how the evidence might apply to the implementation and evaluation of mental health and employment programmes. There is some evidence that organisationally directed interventions appear more effective than individually-directed ones; this obviously implies, for example, that stress management training alone may not be entirely effective in addressing mental health issues in the workplace. But at the same time, individually directed interventions are directly complementary to organisational ones. This raises questions about at what point and under what conditions individual interventions such as training may achieve the critical levels required to have a sustainable impact on organisational culture. Interventions that combine primary prevention with secondary prevention or early intervention are more likely to result in system change than others. On the other hand there have been fewer interventions that have combined recovery based return to work programmes with health prevention, even though this seems desirable [23]. This raises issues about the sequencing of intervention components, for example the potential for primary prevention work with businesses to lay preconditions for greater subsequent success in secondary or tertiary interventions.

Research suggests that workplace interventions can be more effective if they include some or all of the following: employer/employee partnerships, addressing organisational and individual factors, and improving partnerships and communication within partnerships, among professionals [23, 32]. This directs attention to the relationship within complex interventions between different strands, such as workplace settings and healthcare professional or inter-professional settings.

Programmes which are based on particular models for change around 'stress' that look at psychosocial dimensions such as workers' discretion in how they apply their skills, their autonomy, work demand and control can be seen as relating to empowerment [20, 30]. Changing workplace procedures structurally in such as way to increase employee control, reducing work demands, for example, working hours, and increasing flexibility, may benefit more disadvantaged groups the most [34]. On the other hand, individual training programmes which are not accompanied by organisational support may not succeed [33]. Therefore culture change affecting the attitudes and practices of individuals across organisational roles and hierarchies is an important dimension contributing to the success of interventions [33]. A strong implication of this is that programmes need to find ways of examining organisational culture or climate.

The importance of organisational culture can be illustrated by looking at participatory interventions. Participatory processes, such as setting up of working groups or committees that cut across organisational hierarchies have been found to increase workers' control. This is important for individual stress management. However, the benefits of this can easily be offset if organisational hierarchies are rigid so the participatory process is ineffective, and during times of job insecurity, or redundancies with increased stressful working conditions [27]. For this reason it seems important to consider wider systemic and environmental factors when designing interventions, and, in order to win and sustain the trusting engagement of the key people, to factor in a realistic consideration of the climate within which organisations operate and the priorities which influence their culture and language, when setting and assessing project targets, timescales and methods. It may be important to consider carefully how a model of promoting mental well-being (rather than only responding to ill-health) can be

implemented in the prevailing organisational climate, and whether/how that can be done in the context of informing wider practices at work, and taking account of and challenging stigma.

The value of tertiary interventions which support people to return to employment (for example supported employment programmes) has been affirmed [24]. However, the wider, holistic context of recovery needs to be central for those people who have had mental health problems. This means that such programmes are most relevant where they are embedded within a focus on self-esteem, quality of life, and building trusting relationships of hope, as well as on vocational outcomes [21].

In summary, there is growing evidence to support the use of the workplace as a setting for mental health promotion, in line with the aims of the Altogether Better programme. Overall there are seven **pointers for practice**:

1. Simply focusing on the individual alone may often not be the most effective way to address mental health issues in the workplace. In general, the interventions that work best also include a focus on improving the work environment and changing the organisational culture.

2. Management staff should be engaged in the intervention because without the full support and commitment from management, it is unrealistic to expect that interventions will achieve meaningful change.

3. The more effective interventions include those that increase employee control over work & decision making, address both individual and organisational/ environmental factors, and include participatory approaches. These are all consistent with an empowerment process, and as such provide support for the Altogether Better model.

4. Enhancing employees' control over their work may be of greatest benefit to those from more deprived socio-economic groups for whom lack of control is particularly common.

5. The effectiveness of some participatory approaches suggests that paying attention to the ways in which decision making takes place in relation to taking action around mental health is as important as any initiatives subsequently implemented.

6. It should be recognised that there can be practical and cultural barriers to the use of empowerment approaches within the workplace setting. Empowerment as a term may be considered outside the scope of many organisational change programmes and a poor `fit' with a company's core aims and drivers. Careful consideration should be given to the language used in relation to interventions.

7. It is also necessary to give realistic consideration to the climate within which organisations operate and their priorities when setting project targets, timescales and methods.

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Appendix 1 Glossary of key terms

Cognitive behavioural therapy (CBT)	A collection of therapeutic approaches carried out with the aim of solving problems concerning people's emotions, behaviour and thought processes through a goal-oriented, systematic procedure.
Empowerment	Empowerment concerns individuals and communities increasing control over their lives and their health. Individual empowerment is about people having a sense of control over their lives through building people's confidence, boosting their self-esteem, developing their coping mechanisms or enhancing their personal skills. The opportunity to exercise personal discretion/choice and complete meaningful work is an important element contributing to employee engagement and well-being.
Hierarchy of evidence	A hierarchy of evidence is where sources of evidence are graded in order to make statements on the strength of the evidence. Criteria reflect the extent to which evidence is based on strong research design and methods, or has relevance to practice.
Mental wellbeing	Mental wellbeing is a dynamic state in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community.
Psychosocial	Relating social conditions to mental health.
Recovery	Recovery is seen within the recovery model as it applies to mental health as a personal journey, that may involve developing hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills, and meaning
Systematic review	Systematic reviews aim to comprehensively locate and synthesise research that bears on a particular research question using organised, transparent and replicable procedures at each step of the process. Good systematic reviews take precautions to minimise error and bias[1].
Work-place Stress	The harmful physical and emotional response that occurs when there is a poor match between job demands and the capabilities, resources, or needs of the worker

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Appendix 2 Mental Health and Employment search strategy

The key objective of the evidence summary on Mental Health and Employment will be to:

- to produce an evidence summary of interventions related to Mental Health and Employment
- to identify evidence of impact or outcomes from interventions related to Mental Health and Employment
- to identify key models for interventions (to facilitate a comparison between the ATB model and existing evidence)
- to identify factors/mechanisms influencing outcomes of interventions related to Mental Health and Employment

Search terms

Databases	**Target of interventions**	**Outcome variables**	**Influence factors**	**Intervention type**	**Review/ document type**
[CSA] ASSIA Medline Social Services Abstracts Sociological abstracts Worldwide political sciences abstracts **[EBSCO]** PsycINFO Cinahl IBSS **National electronic library for mental health** **DARE**	**Key words** **Organisation*** **Work*** **Employer*** **Workplace** **Business** **Employment** [individuals] **Employee*** **Workforce** **Business champion*** **Mental health first aider*** **Community mental health champion*** **Occupation***	**Key words** **Outcome*** **Impact*** **Process*** **Effective*** [individual outcomes] **Mental health** **wellbeing** **Psychological health** **Stress** **Empowerment** **Recovery** **Coping** **Confidence** **Self-esteem** **Control** **Participation** **Efficacy**	**Key words** **individual** **Stress manag'mnt**, **Skills training** **Advice** **Community /peer** **Support** **Social network** **Participat*** **organisational** **Communication,** **Capacity** **Managem'nt** **Flexible Work**	**Key words** **Intervention*** **Promotion** **Model*** **Strateg*** **Program(me)** **Evaluation** **Evidence** **Initiative**	**Systematic review** or **Literature Review** **Evidence Review** **Evaluation reports** **Official publications** **Policy documents** **Grey literature** **Case studies**

		[Organisational outcomes] **Policies** **Promotion** **Procedures** **Presenteeism** **Absence/absenteeism** **Sick leave** **Early retirement** **Turnover** **Prevention** **Early diagnosis** **Retention** **Return to work** **System** **Capacity**	**Job (Re)Design** **Primary Care**		

Additional search tasks

1. Search of relevant websites for mental health and employment and relevant reviews
2. Free search of Google for mental health and employment and relevant reviews

EXAMPLE SEARCH

Cambridge Scientific Database Abstracts Jan 2000-Dec 2009

SELECTED DATABASES

ASSIA

Medline

Social Services Abstracts

Sociological abstracts

Worldwide political sciences abstract

Bold lines are the initial combinations which were searched for selections.

1. KW employer* OR workplace OR employee* OR workforce OR business or occupation
2. KW mental health OR wellbeing OR psychological health OR stress
3. 1 and 2
4. KW systematic review OR literature review OR evidence review
5. **4 AND 3 [cross check with known existing reviews]**
6. DE support OR KEYWORD stress management OR training OR social network*
7. DE employer* OR workplace OR employee* OR workforce OR business or occupation
8. 7 and 2 –
9. **6 and 8** -
10. KW Outcome* or impact* or process* or effective* -
11. DE communication OR capacity OR management OR flexible work OR job design
12. **11 and 8 and 10**
13. **11 and 3**
14. DESCRIPTOR empowerment OR participation OR control OR recovery OR coping OR confidence OR self-esteem OR present* OR absent*
15. **14 and 2**
16. **KW community mental health champion* OR business health champion* OR mental health first aid**
17. KW primary care
18. **17 and 3**
19. DE Intervention* OR promot* OR model* or strateg* or program(me) or evaluation or evidence or initiative
20. DE mental health OR wellbeing OR psychological health OR stress
21. 20 and 7
22. **19 and 21**
23. **14 and DE 1**

Appendix 3 Inclusion and exclusion criteria

	Included	**Excluded**	**Borderline – reviewed again 2nd stage**
Type of evidence	Systematic review Literature review Expert evidence review Practice based review Other evidence review	Evaluation of single programmes/projects Commentary Professional journals No evidence of review process (description of projects only)	Evaluation of large-scale single programmes where appear similar to ATB model and/or on ATB priorities (mental health) Policy analysis where relevant
Setting	Workplace setting	Not workplace setting Hospitals and care settings Schools	
Target population	All adults	Children	Young people where outside school setting
Intervention	Mental health and employment (including stress prevention or management, common mental health problems, severe mental health problems)	No discussion of intervention	Volunteers

Criteria for strength of evidence

Is publication based on a review of evidence?

High-level evidence

Research based evidence (systematic review)

Research based evidence (non-systematic review)

Expert evidence (review)

Practice based evidence (from review of programmes)

Synthesis of evidence from different sources

Lower-level evidence

Practice-based evidence (from more general review of practice)

Research based evidence (single large scale or LT programme)

Research based evidence (single programme – high relevance to ATB)

Criteria for relevance of evidence to ATB

High relevance

UK context

Related to promoting health around

- mental health and work
- stress at work

Lower relevance

Non-UK

Developing countries

Other health issues

Appendix 4 Mental Health and Employment -data extraction form

Publication:	
Type of study/evidence:	
	Summary of findings
Definitions and theory (of intervention by type/strategic **model**) (summary)	
Roles & activities	
Target community and organisations (settings)	
Implementation	
Individual outcomes for employers or similar targeted roles (direct beneficiaries)	
Individual outcomes for employees re: improved mental wellbeing	
Community (workforce) level outcomes (as in peer support model)	
Organisational (company procedures) level outcomes	
Costs/economic matters	
Key process issues - Influences on outcomes (enablers, constraints)	
Evidence of wider (e.g. other businesses) community engagement	
Comment on strength of evidence. Evidence quality/hierarchy	
Evaluation issues – any research gaps	
Relevance of evidence to ATB	
Summary statement of evidence (2-3 lines max)	

Appendix 5 Summary of data extraction of included reviews

Publication	Type of review	No of studies included	Target of interventions	Outcomes - individuals	Outcomes - organisational	Cost-benefits	Summary statement of evidence	Comments on relevance of evidence for ATB
Bambra et al (2009) Working for health? Evidence from systematic reviews on the effects on health and health inequalities of organisational changes to the psychosocial work environment. Preventive Medicine 48. 454-461	Systematic umbrella review of systematic reviews	7 systematic reviews identified. in North America, Europe, Australasia Japan	Adults 16+ Organisation Level intervention	✓	✓	×	Umbrella review of seven systematic reviews of health effects of organisational level changes to the psychosocial work environment. Changes to employee control and other changes to organisation of work in its psychosocial dimensions have important benefits for health, and may reduce health inequalities.	Socially disadvantaged groups may benefit most from such interventions as increasing employee job control, introducing compressed working week, and implementing structural changes to shift work.
Blaug et al (2007) Stress at Work: A report prepared for The Work Foundation's Principal Partners.	Overview of literature only	-	Primary, secondary and tertiary stress management interventions examined	✓	×	×	Presents an evidence based model of good practice stress prevention and management that was developed by Jordan et al. (2003). It entails both work-related and worker-related strategies. Key factors include senior management commitment, risk assessment and task analysis, a stress prevention strategy, and A participative approach.	If work-related stress is to be controlled, it is not enough to equip individual workers with the techniques with which to deal with potentially stressful situations. There is also a need to diminish the stress-inducing aspects of the job, and to address the sources of work stress that are located in the culture of the organisation
Brown and Kirk (2003) Employee Assistance Programs: A Review of the	General review of the literature incorporating some evaluation	- examines the history of Australian	services include counselling, stress management, critical incident	✓	✓	✓	While research evidence is not fully supportive of the effectiveness of EAPs, data suggests that these	Paper recommends developing a model of EAP intervention that provides guidelines within the context of the

Management of Stress and Wellbeing Through Workplace Counselling and Consulting. Australian Psychologist 38 (2), 138-143	research.	Employee Assistance Programs (EAPs), and evidence for effectivenes	stress debriefing (CISD), wellness programs, mediation, and managerial coaching.				programs do impact positively on employee mental health, and are perceived by employees as a desirable workplace resource. Need stated for EAPs to adopt a broad focus & target organisational change as well as individual change.	dual-client relationship. This should address linkages between organisational sources of stress and stress management interventions, and feedback of information from counselling to management concerning organisational sources.
Corbiere, et al (2009) A systematic review of preventive interventions regarding mental health issues in organisations. Work 33, 81-116	Systematic review	24 studies, literature between 2001-2006. Europe, USA, Canada, Australia, Japan, Hong Kong, and India	8 focused on primary interventions, 14 on secondary, 2 both.	✓	✓	×	Most studies utilised skills training to overcome potentially harmful factors because this is cheaper and easier to implement. One third of studies combined individual group and organisational levels, most often supported by psychosocial intervention approaches and/or participatory research. These brought positive results.	Relevant attempt to identify how interventions may work towards psychosocial change (aspects e.g. participation, control, relevant to empowerment)
Couser (2008) Challenges and Opportunities for preventing depression in the workplace: A review of the evidence supporting workplace factors and interventions. Journal of occupational and environmental medicine. 50 pt. 4. 411-427	Literature review of 'seminal articles'. Synthesis of evidence from different sources.	Not reported. Many studies referenced. English language. Australasia, North America, Europe.	International review focuses on evidence for prevention in context of workplace.	✓	×	×	A proactive, preventive approach is advocated to decrease medicalisation of difficult workplace situations so issues such as conflict could lead to less burnout and depression. The evidence base is inconclusive for which types of interventions would be optimal, but the picture favours prevention coupled with early intervention.	The organisationally targeted as opposed to individually targeted intervention evidence is weak.
Crowther et al	Systematic	11 RCTs. 1966-	International	✓	×	×	Supported employment was	Supported employment,

(2001) Helping people with severe mental illness to obtain work: systematic review. BMJ 322. 204-208	review.	1998.	review comparing prevocational training and supported employment				found to be more effective than prevocational training at helping people with severe mental illness to obtain competitive employment	which proved relatively effective, places clients in competitive jobs without extended preparation and provides on job support.
Dickson and Gough (2008) Supporting people in accessing meaningful work: Recovery approaches in community-based adult mental health services. www.scie.org.uk	Systematic review	21 outcome evaluations 1991 - 2006. 16 US, 3 UK and 1 each in Canada and Europe.	Evidence review of Process and impact of recovery orientated interventions	✓	×	×	There were consistent effects in voluntary work and supported education programmes impacting on self-esteem, and other dimensions of recovery. The evidence shows key components of interventions which contribute to different aspects of recovery, including empowerment.	Highly relevant because it focuses on impact of recovery-orientated training on self-esteem/quality of life. Also the review looks at evidence on process of delivering interventions.
Edwards and Burnard (2003) A systematic review of stress & stress management interventions for mental health nurses. Journal of Advance Nursing, 42(2) 169-200.	Research based evidence (systematic review & meta analysis)	77 articles were included in the review. Only 8 studies were stress management interventions	Stress management encompasses different methods designed principally to reduce stress and improve coping.	✓	×	×	The most effective way of managing stress is to tackle the problem at several levels. The first step is to prevent problems occurring. Management strategies must be proactive, but there is a lack of research into interventions at the organizational level	The majority of studies had a UK focus, but given the fact that the impact of stress management interventions was only a small part of this review, it is probably of quite low value overall.
Egan et al (2007) The psychosocial and health effects of workplace reorganisation. A systematic review of organisational-level interventions that aim to increase employee control. Journal of Epidemiological Health, 61. 945-	Systematic review	18 studies included, 12 with control/ comparison groups (no RCTs).	Site specific organisational interventions designed to increase employees opportunities to make decisions or participate in decision-making processes at work.	✓	×	×	Systematic review of organisational participatory interventions identified evidence of some health benefits occurring when employee control improved or (less consistently) demands decreased or support increased	The effective use of participatory committees/groups to increase employee control, this was offset however by substantial deteriorations in workplace conditions, downsizing, redundancies

954.								
Giga et al (2003) The UK Perspective: a review of research on organisational stress management interventions. Australian Psychologist 38 2 158-164.	Comprehensive literature review includes evaluation research or research involving a systematic study with control group	16 studies aiming to examine types of Stress Management interventions in UK	Job stress interventions aiming to a. prevent stressful situations, b. reduce intensity of exposure c. help equip people to cope	✓	✓	×	Majority of interventions target individual employee. Study concludes that interventions including organisational components or individual-organisational interventions more likely to have lasting impact than just individual ones. A participatory approach would make programme less transitory (more sustainable)	Effectiveness of studies with Participatory Action approach suggests decision making processes used to develop stress prevention/reduction strategies are just as important as the strategies themselves.
Hill et al (2007) What works at work? Review of evidence assessing the effectiveness of workplace interventions to prevent and manage common health problems. Institute for Employment Studies. Crown Copyright.	Evidence review	English language reviews including work-based and health outcomes – total of 10 studies (inclusion dates 2000-2006).	The review includes interventions addressing common mental health problems.	✓	✓	×	Interventions obtain better results with employer/employee partnerships, and if a person's attitudes/beliefs as well as condition are considered. Interventions should be 'comprehensive' i.e both functioning organisationally and individually.	The study highlights the importance for workplace interventions of a number of key factors employer/employee partnership, addressing organisational and individual factors, and improving interprofessional communication

Kitchener and Jorm (2004) Mental health first aid training in a workplace setting: A randomized controlled trial. BMC Psychiatry 2004: 4:23	Randomized controlled trial of mental health first aid training. 2002.	Data reported on 301 participants randomized to either participate immediately on course or wait for 5 months to do so.	Mental Health First Aid course consists of 3 weekly sessions, 3 hours each.	✓	×	×	RCT of MHFA training course found that benefits from course included greater confidence, likelihood of advising others, concordance with professionals, decreased stigmatizing attitudes. Effective in improving Mental health literacy and mental health. High applicability across community.	Benefits from MHFAT are that intervention group showed greater confidence in providing help to others, greater likelihood of advising people to seek professional help, improved concordance with health professionals in beliefs
Kuoppala et al (2008) Work health promotion, job well-being, and sickness absences. A systematic review & meta-analysis. Journal of Occupational & Environmental Medicine, 50 (11), 1216-1227.	Cohort studies, RCTs, trials, cross-sectional studies,	46 studies were included in the review	Studies in the following occupational settings: industrial; health & social care; office; transport; sales; maintenance; mixed/unspecified.	✓	×	×	WHP increases mental well-being, but not physical well-being or general well-being. WHP also seems to promote work ability & decrease sickness absences. Education & psychological methods applied alone do not seem effective.	Employee-employer trust may enhance the attainment of intended results in WHP. Active participation of the employees in the planning and execution of WHP programs is a way to diminish paternalism. WHP best if integrated into company functions.
Lamontagne et al (2007) A systematic review of the job-stress intervention evaluation literature, 1990-2005. International Journal of Occupational and	Systematic review	Review of 90 reports of systematic evaluations of job-stress interventions	Wide range of intervention targets across studies. These include physical work environment, organisation, organisational/individual	✓	✓	✓	Organisationally focused approaches (combining prevention and intervention) are beneficial at both individual and organisational levels. High systems approaches (Primary and secondary approaches combined) are most effective in addressing impacts of job	Organisationally-directed interventions appear more effective than individually-directed ones. But at same time, individually directed interventions are essential complement to organisationally directed, to increase psychosocial

environmental health. 13, 268-280			interface, and individual.				stress.	dimensions such as control and participation.
Lelliott et al (2008) Mental Health and Work Royal College of Psychiatrists.	Evidence review	Includes 10 systematic reviews of interventions around severe mental illness and work	Review of evidence about what works; includes (primary, secondary and tertiary); and counselling and employment assistance programmes	✓	✓	✓	Multimodal or many-facetted interventions are more effective than single method ones. Individual stress management interventions are most effective for retention of those at risk. For recovery/rehab, CBT is effective, with a stronger effect for employees in high control jobs.	There is a triple focus on prevention, retention, and 'rehabilitation', all concerning common mental health problems. There is also comparison of individual level and organisational level interventions. The lack of focus on process is a limitation.
Martin et al (2009) Meta-analysis of the effects of health promotion intervention in the workplace on depression & anxiety symptoms. Scandinavian Journal of Work, 35 (1) 7-18.	Systematic review & meta analysis	22 studies were included in the review. 17 were included in the meta analysis	The workplace intervention had to target mental health directly or indirectly through a known risk factor for depression or anxiety	✓	×	×	There were small positive effects for symptoms of depression & anxiety in the interventions reviewed but no effects for the composite outcome of the mental health measures. The interventions with a direct focus on mental health had a similar beneficial effect on symptoms as those with an indirect focus on risk factors.	Comments on lack of organisational interventions. Has been suggested that organisational interventions may take longer than the average 3-12 month follow up period to demonstrate an impact.
Murta et al (2007) Process Evaluation in Occupational Stress Management Programmes: A Systematic Review. American Journal of Health Promotion 21 (4) 248-254	Systematic review of workplace stress management intervention studies that incorporate process evaluation	84 studies met inclusion criteria, of which 52 reported findings on at least one of process relevant variables	Two thirds of interventions were in health care, educational and industrial settings	✓	✓	×	Greater involvement and support from supervisors and managers leads to better intervention implementation and likely outcomes. More positive participant perception of warmth and safe climate means greater likelihood of affecting job-related stress	The importance of process evaluation is confirmed, but it needs to be linked to outcome evaluation to be of maximum use
NICE (2006) Workplace interventions that are effective for promoting mental	Systematic review.	66 primary studies included	Review identified workplace based interventions effective in	✓	×	✓	Publications relating to interventions intended to improve mental wellbeing in workplace cover a wealth of different interventions and	The problem appears that the organisational level Randomized Controlled Trial interventions are not

wellbeing. Synopsis of the evidence of effectiveness and cost-effectiveness			improving wellbeing. Studies grouped as organisational or stress management interventions.				outcomes. Organizational and individual level interventions both have a place, and economic modelling supports the business case for interventions.	producing consistent demonstrated individual outcomes. This raises issues that the RCT approach may not address intervening or multi-influence processes – these intervening processes need to be explored and understood.
Richardson & Rothstein (2008) Effects of occupational stress management intervention programs: A meta analysis. Journal of Occupational Health Psychology, 13 (1) 69-93.	Research based evidence review(meta analysis)	38 articles were included, representing 55 interventions.	All included studies were an experimental evaluation of a primary or secondary occupational SMI.	✓	✓	×	The results indicate that there is value to SMI programs. Individual employees can be taught techniques to reduce their stress levels. Nearly all of the subcategories of interventions produced meaningful effects, but cognitive–behavioural programs consistently produced the largest effects.	Cognitive–behavioural interventions, though effective, are generally taught by a trained professional in a group session, and require more organizational resources than other interventions like relaxation techniques.
Rick et al (2002) Review of existing supporting scientific knowledge to underpin standards of good practice for key work-related stressors – Phase 1 Institute for Employment Studies. Health and Safety Executive 2002. Research report 024.	Longitudiinal studies Including meta-analysis or literature review, and empirical papers (randomised controlled trial, a full field experiment, a quasi-experimental design or a longitudinal study).	8 papers provided evidence on the impact of various organisational interventions on the stressors; 17 studies, including 3 meta-analyses, addressed effects of stressor on health, well-being and organisational performance.	Review.on: nine stressors; effects on health well-being and organisational performance, process mechanisms; organisational activities which reduce stressor levels; effects of this on health, well-being and organisational performance	✓	✓	×	Interventions at an organisational level generally have positive effects on reducing levels of the nine stressors. The mechanisms through which stressors affect health include combined effects, indirect links and non-linear relationships. The stressors themselves can be viewed in relationship to empowerment e.g. (lack of) skill discretion, and decision authority.	The focus on organisational rather than individual activities is very useful. The focus on stressors and mechanisms is relevant to empowerment at work insofar as aspects such as skill discretion, autonomy, demand and control represent dimensions of empowerment at an individual level which can be affected by system level interventions.

Ryan et al (2005) Team-Based Occupational Stress Reduction: A European Overview from the Perspective of the Oscar Project. International review of psychiatry, 17(5), 401-408.	Review of large scale project researched comparatively across six European centres.	Longitudinal study, three repeated measures taken at baseline, six months after training and twelve months after.	Same staff group including both community and in-patient teams trained in an interventions strategy to reduce levels of stress and increase efficacy of risk assessment. Whole team approach.	✓	✓	×	Team-Based Occupational Stress Reduction programmes did not achieved desired reductions in stress burnout depersonalisation and exhaustion. Senior managers resisted requests for change. For training to be effective mechanisms needed for ensuring greater organisational responsiveness. Otherwise training can be counterproductive in some ways.	The study highlights limitations of training without organisation wide change – this is an empowerment issue for workplaces.
Seymour and Grove, (2005) Workplace Interventions for People with Common Mental Health Problems. British Occupational Health Research Foundation.	Systematic review	111 papers critically appraised. 19 experimental studies included.	Focus on prevention, retention and rehabilitation of people with common mental health problems.	✓	✓	×	A range of stress management interventions showed beneficial preventive effects, and employees gained skills. Multimodal approaches have greater benefit. For retention at work of those at risk most effective programmes focused on personal support, individual social skills, and coping skills training.	Organisational interventions should be designed to include individual training e.g. around coping skills so that enhanced organisational benefits such as opportunities for more job control or increased participation may be used by individuals.
Waddell and Burton (2006) Is Work Good for You? London. TSO	Systematic evidence review (umbrella review) 46 reviews.	Existing literature reviews from 1990-2006 were included. Greatest weight was given to systematic reviews.	Report Highlights results for evidence review on severe mental illness, common mental health problems, and stress	✓	×	×	*Severe mental illness* Supported employment programmes are effective *Common mental health problems* Limited evidence *Stress* Longitudinal studies support causal relationship between psychosocial characteristics around demand and control and mental health over time	Understanding and addressing common mental health problems requires a biopsychosocial approach taking account of the person, the health problem and the work environment.

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Robinson M., Raine G. and South J. (2010)
Mental Health and Employment: Evidence Review.
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