Better Guidance on Managing Common Mental Health Problems in the Workplace:

Supplementing What With How

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Abstract

There are many actions employers can take to help prevent common mental health problems occurring in their workplaces and help those affected return to work at full capacity. However, working age common mental health problems in developed economies are persistent and resistant to change. Because of the complex etiology, recurring and often chronic nature of common mental health problems, solutions based purely on workplace regulation are not feasible. Instead, regulatory agencies may supplement regulatory frameworks with guidance on good practice. I review guidance frameworks influential in the UK (three issued by governmental agencies, two by non-governmental agencies), indicating guidance is relatively strong on what to achieve but less so on how to achieve it. Drawing on research on the implementation of workplace health and wellbeing initiatives, I suggest ways in which guidance from regulators can be extended and how that guidance can best influence organizational practice.

(146 words)

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1. Introduction

Work-relevant[1] mental ill-health is a persistent and pervasive source of chronic sickness absence, worklessness and disability in developed economies (Etuknwa and Mathai, 2021), placing burdens on tax systems through higher spend on healthcare, unemployment benefits and lower productivity. There is evidence that the incidence of work-relevant mental ill-health may have increased post-Covid compared to levels pre-Covid (Gallie, Daniels and Hoque, 2022). Statistics from the UK indicate 'common' mental health problems (i.e., anxiety, stress, and depression) are by far the most frequent of work-related illnesses, accounting for 48% incidences of work-related illness, with the next most frequent category accounting for under 30% (Health and Safety Executive (HSE), 2021).

It is the case that governments can act through changes to employment legislation to provide greater employment protections that may reduce the risk of developing mental health problems (e.g., around rights to flexible working, employment security, working hours, rates of pay) and through legislation protecting the rights of workers with mental health conditions. Rights for workers with mental health conditions can include rights to access, for example, the same employment, training, and career development opportunities as other workers (equality, diversity, and inclusion legislation). Rights for workers with mental health conditions can also include requirements to make workplace accommodations for workers with mental health conditions. However, it is perhaps not feasible to consider legislation as the only means of reducing societal burden and suffering from work-relevant mental ill-health (Mishiba, 2020).

[1] I use the term work-relevant rather than the more common work-related because although work can be the cause of mental ill-health, it is also the case that workers may develop mental health conditions due to other reasons, yet remain in work. In this case, workers may display behaviours, for example lower performance and absence from work, due to their condition that are relevant to the workplace yet not related to their work. See Kendall, Burton, Lunt, Mellor and Daniels, 2015.

In respect of prevention, it is difficult to specify precisely what constitutes a mentally-healthy or unhealthy job because of the multifaceted nature of well-designed jobs (Irvine, White and Iffley, 2018), dose-response relationships are difficult to establish, and there are wide individual differences in how individuals respond to the same levels of exposure to poorly-designed jobs (Rick and Briner, 2000). In respect of equality, diversity, and inclusion legislation, difficulties occur in relation to reasonable accommodations or adjustments to working practices. Difficulties may arise in comprehensively specifying accommodations for all conditions. This is especially so for mental health conditions, where work-relevant symptoms may manifest themselves in different ways for different workers. Further, because symptoms may fluctuate, requirements for accommodations are unpredictable (Kendall et al., 2015). Moreover, for both prevention and workplace accommodations, it is also difficult to specify the lengths to which employers should go in any given instance. In UK legislation, these thresholds are defined 'as low as reasonably practicable' for prevention and 'reasonable' for accommodations. Further, for accommodations, these are usually dependent on workers disclosing their condition. Workers may be reluctant to disclose for a variety of reasons, including the nature of the workplace culture (Hemming, McDermott, Munir and Burton, 2021).

Given difficulties with a purely 'hard' legislative approach (Mishiba, 2020), we can therefore expect legislation to be supplemented with guidance on how to achieve compliance. The first purpose of this paper is therefore to review the guidance issued by both the UK Government and other guidance issued by non-governmental organizations that are influential in the UK. The second purpose is to consider how that guidance may be improved. In performing the review, we will highlight what guidance does cover, where current guidance could be improved, the scientific evidence that could underpin such improvements and how policy makers could best disseminate and organize improved

guidance. Before reviewing this guidance however, we will briefly outline the actions employers can take to help protect workers' mental health.

1.A, The actions employers can take The actions to protect or even enhance workplace mental health and wellbeing are often categorized as (Daniels et al. 2021; LaMontagne et al. 2007; Richardson and Rothstein 2008) as:

i) Primary through work redesign. These are actions designed to prevent harm or promote health through changes to jobs and management practices to minimize exposure to harmful psychosocial conditions. Examples include line manager training, flexible working, problem-solving circles to promote social contact, changes to shift patterns.

ii) Primary through health promotions. These are actions to prevent harm or promote health to encourage behavior change so that workers adopt healthier life-styles. Examples include workplace health education targeted at improving financial literacy as well as actions primarily focused on physical health but that can also promote psychological benefits such as gym membership and workplace exercise classes.

iii) Secondary. These are actions to prevent harm or promote health so that workers can self-regulate exposure to risks to wellbeing. Examples include training for stress management, resilience, and mindfulness. Note that these interventions do not in themselves reduce exposure to psychosocial risks in the working environment.

iv) Tertiary. These are actions designed to rehabilitate those who have developed health conditions. Examples include phased return to work and temporarily removing some designated tasks.

Reviews of scientific evidence indicate that interventions in the broad categories listed above can be effective (for a review of reviews, see Daniels, Watson, Nayani and Tregaskis 2022). However, there is unevenness of effectiveness across interventions, even for those founded on well-developed theoretical principles and a robust underpinning evidence base. There is a long-standing recognition that, in common with other complex interventions, how workplace interventions are implemented can influence whether an intervention is effective, ineffective, or even harmful (Egan, Bambra, Pettigrew and Whitehead, 2009). Therefore, researchers and practitioners and have developed frameworks to guide better implementation of interventions and research on implementation (examples include Campbell, 2014; Nielsen and Randall, 2013, von Thiele Schwarz, Lundmark and Hasson, 2016).

2. Current UK guidance

Several different guides are likely to be influential in the UK. Two are issued by Government agencies (Health and Safety Executive (HSE) Management Standards for Work-Related Stress, and Department of Work and Pensions Disability Confident scheme), and two are guides issued by influential non-governmental organizations (National Institute for Health and Care Excellence (NICE), International Organization for Standardization (ISO)). A fifth was introduced by Public Health England (PHE) (Workplace Wellbeing Charter) and is accredited by an independent provider (Health@Work). PHE is a now disbanded agency of the UK Government department the Department of Health and Social Care.

Guidance issued by the HSE focuses primarily on what employers can do to prevent problems from occurring in the first place, and so become compliant with requirements under the UK's 1974 Health and Safety at Work Act. It provides a stepped, planned approach to prevention, but also recommends steps are taken to ensure that employers can respond in a timely manner to individual concerns that may not be work-related either before mental

health problems occur or as soon as possible after mental ill-health is detected. Similarly, guidance issued by ISO focuses largely on prevention of problems through a planned approach to changing jobs and management practices to remove potential sources of psychological harm (see British Standards Institute (BSI), 2018; ISO, 2021).[2] HSE and ISO guidance also indicate the importance of management commitment, worker involvement in decisions, recording and monitoring actions, and continuous improvement.

The Disability Confident scheme provides guidance for employers on employing people with disabilities and health conditions. It is not focused on mental health *per se*, and so provides generic guidance. Disability Confident is not focused on preventing mental ill-health in the workplace but could be seen as complimentary to the HSE Standards[3]. Disability Confident covers topics such as reasonable adjustments and recruiting workers with disabilities and health conditions. Disability Confident also provides encouragement and guidance on reporting on how employers support recruitment and retention of workers with disabilities and health conditions, including articulating clearly how workers are supported and their progression in work.

NICE recommends a comprehensive and strategic approach to supporting and promoting mental wellbeing at work, and includes specific references to the HSE Standards, Disability Confident, and other resources. The guidelines cover all four categories of action listed above (i.e., primary through work design, primary through health promotion, secondary tertiary). Going beyond employers, NICE also recommend that local and regional authorities integrate mental wellbeing at work into their public health activities and strategies (for an example, see PHE, 2019). In making recommendations to local and regional authorities,

[2] In respect of common mental health problems, the relevant guidance supporting the general guidance compliance with the ISO on workplace health and safety is contained in two documents, one published by the BSI (2018, the UK body within ISO) and one published by ISO (2021).
[3] However, there are no salient links between HSE and DWP on the respective websites.

NICE explicitly acknowledges support provided directly to employers may not be sufficient for action.

The Workplace Wellbeing Charter aims to provide a framework for employers to take a systematic approach to workplace improvements in health and wellbeing, as well as provide standards to support local authorities to support employers. The Charter is based on three elements of leadership, culture and communication, and there are 95 standards grouped in eight areas (e.g., mental health, physical activity, healthy eating). To achieve accreditation, external consultants support with assessment, benchmarking, and developing action plans. A report into the Workplace Wellbeing Charter (Hofman, Garrod, Stewart, Stepanek and Van Belle, 2018) concluded adopting the Charter was associated with several improvements, for example in sickness absence and job satisfaction, and could benefit organizations through encouraging innovation, accelerating change and monitoring of improvements. However, the same report concluded that the accreditation process was time-consuming, particularly for smaller organizations. Having sufficient time to act has been identified as a generic problem for organizations wishing to address workplace mental health and other wellbeing problems (Fullick, Maguire, Hughes, and Leary, 2019).

HSE and ISO guidance focus on a critical element of preventing common mental health problems in the working age population through making improvements to jobs and management practices. Although the emphasis is largely on prevention in these guides, organizational support for rehabilitation/return to work should not be discounted, elements of which are addressed in Disability Confident. NICE recommendations are comprehensive, covering prevention, rehabilitation/return to work, and other potential actions. NICE recommendations do not explicitly address continuous improvement. However, internal monitoring (embedded in HSE, ISO, Workplace Wellbeing Charter) and voluntary reporting of actions (embedded in Disability Confident) are levers to sustain continuous improvement

processes that underpin sustainable approaches for workplaces to reduce the incidence of common mental health problems.

Much of the content of current guidance is focused on ‘what’ - what to do or what to achieve, rather than the how these states are to be achieved. Aside from some recommendations (e.g., embedding continuous improvement), current guidance could be augmented to provide more information on how to make changes to how jobs are performed, how to manage employees with mental health conditions and how to manage long-term, coherent programs of activities that address different forms primary, secondary, and tertiary interventions.

3. How do employers make primary, secondary, and tertiary interventions work?

A systematic review of implementation of 74 workplace health and wellbeing initiatives (Daniels et al., 2021) found evidence that interventions can be successfully implemented in workplaces, even where there are obstacles to be overcome. Obstacles can include challenges in securing financial resources, finding time and access to relevant, specialized professional knowledge. Other obstacles that can be overcome include worker distrust and cynicism with management because of a history of failing to address on-going problems with jobs, employment conditions or management practices. Moreover, the same review did find that interventions may not always be effective in supportive contexts (e.g., access to financial resources). The review examined interventions, whether targeted at physical or mental health, that evaluated the impact of interventions on markers of mental health or the related concept of psychological wellbeing. The review examined interventions that were classified as primary through work redesign, primary through health promotion, secondary, and tertiary. The review identified three critical success factors for implementation of effective interventions that apply across intervention types. Case study research (Daniels et al., 2022)

provided further detail on these critical success factors. The critical success factors identified by Daniels et al. (2021) are:

i) Continuity or persistence of efforts of key change agents to implement and adapt interventions to local contexts.

ii) Learning from efforts to implement, which facilitates adaptation of the interventions. Learning and consultation processes capture workers' views on what should be improved and, once change processes are underway, facilitate modifications to implementation plans according to feedback. Consultation processes are also important to explain to workers what cannot be changed. Further, learning processes support embedding a continuous improvement process. In turn, continuous improvements facilitate an evolving pattern of actions around mental health that ensure that changes in other organizational processes and management practices are made in a way that also protects or even enhances mental health.

iii) Functional governance structures (e.g., steering groups, task and finish groups) that include a range of stakeholders, including workers as well as senior managers and wellbeing/mental health 'experts' (human resources and/or occupational health professionals). These governance structures provide an administrative and co-ordination function, including the means to capture workers' views and learning from change initiatives. Governance structures also provide a symbolic and political function, signaling the importance of the changes and potentially co-opting 'mental health' sceptics into the decision process.

Further, for multi-faceted programs, of the kind recommended in guidance, it appears important to make clear connections to other workplace health and wellbeing initiatives,

usually through communicating that a range of activities are part of a coherent strategy, so that workers are aware that the organization is taking action on mental health (Daniels et al., 2022). This communication along with a range of initiatives may increase the 'signal' strength so that workers are more likely to notice changes, which in turn fosters perceptions of organizational support. Further, it appears there is an important communicative function in adapting initiatives and, if necessary, introducing new initiatives to address changing circumstances. This communicative function relates to the authenticity attributed by workers to organizational actions around mental health (Nayani et al., 2022).

Daniels et al. (2022) also found that implementation also requires a clear business case to motivate action around mental health. The business case needs to: a) articulate how changes address issues of strategic value to the organization; and b) simultaneously convey a people-centered approach to the business. That is, the business case articulates how addressing worker concerns about mental health addresses a strategic organizational issue but conveys that worker mental health is a social good is its own right, not merely an instrument to achieve economic benefits. The function of this business case is not merely to secure resources (e.g., financial, time) to make changes, but also to create an evolving narrative to counter arguments that resources and priorities should be directed elsewhere. The importance of an evolving narrative lies in the dynamic nature of organizations, that counter arguments also evolve, the need to ensure continuity in the implementation of interventions, and continuous improvement.

Further, Daniels et al.'s (2022) research also examined the processes through which adaptations were made so that the interventions worked alongside other organizational processes, systems, structures, and practices. For example, Brook and Kemp (2021) report an increase in management time needed to administer a new rostering system introduced to enable flexible working practices. Daniels et al. provided evidence for three processes. These

processes are not mutually exclusive, can proceed simultaneously or one process can enable another. The processes are labelled grafting, fracturing, and Gestalting.

Grafting entails adapting an intervention so that it is consistent with existing processes, systems, structures, and practices with the purposes of minimizing disruption from the implementation of the intervention to the wider organization. This can entail using existing processes, systems, structures, and practices to deliver an intervention. For example, Daniels et al. (2022) report an example of performance appraisal processes being used to facilitate discussions around health, wellbeing, and development activities. Daniels et al. also report cases of where spare capacity in existing resources (rooms, client yoga classes, staff intranets) allowed easy repurposing of those resources for staff health and wellbeing activities. Introducing interventions so that they minimize disruption to the rest of the organization is the approach recommended in much of the literature (e.g., von Thiele Schwarz et al., 2021).

Fracturing is a process of adapting the organization so that organizational processes, systems, structures, and practices do not disrupt implementation and sustaining of the intervention. Fracturing therefore entails seeking conflict with the wider organization. Fracturing might be appropriate where aspects of jobs or management are harmful to mental health (e.g., bullying) and where there may be aspects of the organization that reinforce these harmful aspects (e.g., long hours cultures inculcated by reward systems based on tournaments between individuals). Fracturing is evident processes that encourage people to speak out when they see examples behavior or displays of attitudes antithetical to supporting mental health in the workplace. If supported or displayed by senior management, fracturing may serve a symbolic purpose, acting as a signal of an intention to change workplace cultures and norms (cf. Johnson, 1990).

Gestalting is a process of bringing together multiple initiatives under a common purpose. This might be evident in extensive changes to employment and management practices that are integrated to support mental health or wellbeing (Daniels, Gedikli, Watson, Semkina, and Vaughn, 2017) as well as in developing coherent, strategic, programmatic, and multifaceted approaches to workplace mental health as noted above. Daniels et al. (2022) also give the example of an organization where existing initiatives were brought together to be supportive of worker health and wellbeing. These initiatives were disparate and located in different areas of the business, for example being part of corporate social responsibility, diversity and inclusion, human resources management, and facilities management.

To summarize this section, it appears that processes involved in successful implementation of workplace mental health interventions involve adapting the interventions, based on learning and inclusive governance. Further, activities need to be underpinned by a business case and a programmatic and strategic approach to workplace mental health. Finally, attention needs to be paid to how mental health interventions connect and interact with the wider organization, involving to different degrees adapting the intervention(s) to fit the organization, adapting the organization for fit the intervention(s), and bring disparate activities together. Current guidance could therefore be supplemented by providing information on these processes of implementation.

4. How else might guidance evolve?

One approach is to develop guidance much further to integrate what is missing from current guidance. For example, and as noted in the previous section, this could include more information on implementation underpinned by existing research evidence on implementation. In addition, there are potential directions in how guidance is disseminated. These relate to roles for local government and industry bodies.

In the UK, public health departments are situated in local government authorities (e.g., at city or county level). There is therefore potential for local government to act as conduit for guidance and to encourage employers to engage with extant guidance. In the UK, occupational health is provided through a market mechanism, which contrasts with the public delivery of healthcare by the National Health Service. Local government public health departments could act to link employers with providers offering evidence-based services and identify gaps in local provision of occupational health services. Further, local government public health departments could curate and develop existing guidance to be suitable for local contexts[4] and signpost that curated material to local employers. Finally, local government public health departments could work with other local/regional organizations, such as regional business support organizations and universities, to promote good work and mental health and evaluate interventions. In evaluating interventions, public health departments would have an evidence-base on which to adapt guidance to local contexts.

As well as local government, some industry sectors transcend geographical regions and/or have common challenges (e.g., major infrastructure, transport). In some cases, therefore, a better means of disseminating guidance might be through establishing sector level organizations that have mental health as part of their remit. Current examples from the UK include Rail Safety and Standards Board (rail), Mates in Mind (construction), and Education Support (primary and secondary education), as well as umbrella organizations such as the Council for Work and Health. Like local government public health departments, sector level bodies could curate, develop, and disseminate guidance for their contexts, potentially working with other business support organizations and universities.

[4] As recommended by NICE.

Within improved guidance, there remains a potential role for central, national government[5], in commissioning improved guidance, disseminating guidance to local government and sector bodies, and establishing and organizing a common, multi-layered framework. A common framework for work-relevant mental health provides a means for central government to communicate to employers and the public the activities that central and local governments, as well as sector bodies, are pursuing. For example, a common framework to mental health would link support for local government public health departments with guidance such as Disability Confident and legislation around, for example, flexible working, skills development, and the minimum wage. It does not require the primary purpose of any single activity to be reducing the burden of working age mental ill-health but would allow central government to communicate how multiple activities at all levels of government are being used to address common mental health problems.

5. Conclusions

In the present paper, I have made recommendations on how guidance for employers on mental health might be extended, by augmenting guidance with information on how to implement mental health initiatives in the workplace, how to improve dissemination of guidance, and how to tailor that guidance to local or sectoral contexts. The recommendations are based on a review of guidance issued in the UK. Reviews of guidance from other national contexts may offer further insights.

There are other mechanisms other than improvements in access to guidance through which employers might be encouraged to adopt better practices in respect of reducing the burden of mental ill-health in working age adults. These may include requirements for employers to make public reports on their policies and practices in respect of workplace

[5] The UK consists of three devolved administrations (Northern Ireland, Scotland, Wales), plus central UK government. These recommendations could apply to devolved administrations or centralised, national government agencies.

mental health, encouraging employers to sign charters that include commitments to addressing workplace mental health, and accreditation of employers for adopting good practice. Such other mechanisms could be developed with reference to guidance documents, such that the various mechanisms adopted are mutually supporting.

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