Mental wellbeing at work
Stakeholder workshop
16th July 2019

Area of scope	Questions	Stakeholder responses
3.3 Activities, services or aspects of care (Key areas that will be covered)	1. We have proposed structuring this update using the groups and approaches identified in the Thriving at Work report (the Stephenson/Farmer review): universal interventions for all employees along the full continuum of mental wellbeing, targeted interventions for employees with symptoms of poor mental wellbeing, and tailored interventions for employees with a diagnosed mental health condition. a) Do you agree with this approach? Can you envisage any disadvantages of it? b) Will this mean that any groups are missed?	**Group 1:** The group stressed the need to link physical health and mental health and to start by setting the context of overall wellbeing and looking at both physical and mental health together. It was suggested that a biosocial model would be appropriate to structure the work The group felt that terminology is critical. For example, mental health is probably not same as mental wellbeing. The group suggested we move away from public health terminology and make it more accessible. The group suggested considering adjustment for people with mental health conditions and the promoting access to work scheme which fits in with training of managers and ensuring that managers are not just signposted but educated. The group felt we need to factor in high risk occupations and focus on people who have symptoms that could affect them in the workplace. They noted that no facts and figures were given at the employer level and the focus should not just be on government. This will help with getting buy in from employers.

	c) Are there any sub-groups that should be identified for special consideration?	**Group 2:** The group did not agree with the use of a single continuum – poor mental health and good mental well-being are not opposite ends of same continuum – you can have a diagnosed mental health condition and still be thriving. Others agreed that continuum should be removed. Power-threat-meaning framework was suggested as an alternative. It was suggested that the dual continuum is a more appropriate framework to use; possibly from MIND / time to change England. The group felt the scope document is very diagnosis-led with clinical language. It was suggested to consider the BPS published document on the Power-threat-meaning framework that is garnering growing interest and momentum in public health services. They noted that there is nothing in it at the moment about workplace health, but they may wish to contribute on this. The group felt that social organisational approaches need to be delivered at all levels – it was only suggested for universal approaches in the scope. Organisational approaches include understanding the condition; how the person can be supported; being open about it; encouraging managers not to be scared of having conversations about mental health; have compassion. They felt social model approaches are required throughout – universal; organisational at all levels. **Group 3:** Overall the group agreed with the approach. They noted that issues of staffing make it difficult for staff to undergo mental health support and that employers want to see an immediate return on investment, but that

		in this area it takes time. It is hard to show that there is an immediate return, as it is difficult to measure preventing poor mental health. There is a solid business case to support a whole organisational approach to improve wellbeing and this is very important, training mental health first aiders is not enough. They noted that the evidence base is different for MHFA and EAP so suggested these should not be given as examples in the same sentence of the scope. Training needs to be in work time. The focus on interventions should be on earlier intervention in identifying people with poor mental health. There is an issue around medical confidence in that occupational therapists are not able to disclose where someone has identified with a mental health condition. The group felt that a lot depends on the culture of the organisation, austerity and cuts can affect mental health. They noted that there is nothing in the scope about public mental health and change in the organisation - how change is managed and organisational development. We need to recognise that staff welfare is patient care - they are not two different things (NHS example). Strategic interventions need to focus on engaging with staff, not focusing on mental health when too far progressed - we need to focus on prevention. We need to look at emotional resilience of people who come to work, including managers (build from the bottom). Everybody is at risk of work stress, people will access things at different times depending on stress source - needs to be longevity There is research by CIPD suggesting the difficulty for employers in terms of intervening in stress relating to personal stress. We should

		look after the employee as a whole, not just stress related to work, it should include domestic related stress. This would affect the type of intervention that needs to be put in place. The group noted that the language used is important. Universal intervention is not how it works in practice- everybody is so different. It was suggested that we need organisations, like HSE, to measure suicide, attempts and ideation amongst employees; and that organisations are scared due to manslaughter litigation cases, we need to change this so they are responsible. Organisations can build things in initially to identify key policy and measures on valuing staff, engaging them in the process to promote positive mental wellbeing earlier on to ensure don't neglect people with earlier symptoms. Important as what you measure drives policies and intervention- need early intervention support and support for those later on. The group suggested we should advise organisations to collect their own data, which will help to guide interventions. **Group 4:** Overall they felt that the broad areas make sense, but emphasised that they need to be linked together and integrated into structured leadership and management. Applying interventions universally isn't likely to work – different reasons need to be considered even if universal language is continued.

		The group suggested we need to make sure the guidelines make it specific that all areas are inter-dependable on each other. We need to make the overlap with NG13 clear. They felt that the linear approach of Farmer/Stephenson is helpful but too simplistic for real life. The presentation of the framework is important and perhaps presenting it differently with maybe more narrative around it would be better. Need to consider the different players and how they interact and the different journeys of different staff. They noted that an individual can be diagnosed with a mental health condition and be thriving, we need to bear this in mind. Targeted support needs to be about keeping people well, mental health first aiders are reactive. Mental health champions should be considered. The group discussed that a one fits all approach for interventions is not appropriate. Companies need to audit what interventions will work for them and universal approaches may have no impact on certain sectors of the workforce. Targeted and tailored approaches need to happen earlier as its not universal at the beginning. There is a very large range of people to think about and how to target them – universal approaches may not fit. Issues that are important include pre, peri natal and menopause times; leadership from the top, looking after and retaining staff big in the NHS. Workplace culture is imperative.

3.3 Activities, services or aspects of care (Key areas that will be covered)	2. In addition to the three key areas in question 1, we have identified two further key areas to focus on: training for managers and identifying employees at risk of poor mental wellbeing. a) Are these important for us to focus on? b) Have we missed any key areas or issues?	**Group 1:** Generally agreed that these are important areas. It was suggested that there is perhaps a gap around how managers can help/support employees. What is sensible and at what point should mangers refer? What is the minimum support managers should know and provide? **Group 2:** The group noted that the focus appears to be on training managers to deal with issues rather than making it a good / positive place to work; and that we should add in preventative elements: • Not just training to deal with problems but positive, preventative outlook. • Addressing mental health stigma; compassion. • Reclaim conversation about mental health between staff and managers – promote first levels of conversation rather than it being batted straight to HR or occupational health. • Also train managers on self-care; how to take care of their own mental-wellbeing, self-compassion, a desire to take care of people in the workplace. The group suggested we look into HSE's 'Line-manager competencies for managing stress' and the Institute for Employment Studies' review from 2018. There was some agreement that there is no need to develop further reports or recommendations (are people overwhelmed with

		information?) but they need to be supported to understand and implement it – it was felt to be about changing practice rather than more evidence and the focus could be on implementation not content – questions focused more on embedding training, implementing it, delivering it. The group indicated the importance of training people to understand what's out there and how to access it, particularly those in small organisations – e.g. people who work in a small shop may need training in how to locate and access the information they need. **Group 3:** It should not just be about the employer identifying and also encouraging the employee to identify any possible mental health challenges/ issues, but getting employees to recognise this themselves and monitor their own resilience and wellbeing. This can be done during the induction at the very early stage and managers can be aware of policies to ensure reasonable adjustment. There should be universal training for all employees on mental wellbeing and additional training for line managers. Identifying people at risk- there is a voluntary aspect that they have the awareness and trust to confide in you. Very brief awareness training about myths is appropriate e.g. crib cards to open up a conversation for managers to make sure that they aren't make the employee feel worse about opening up. Signposting from line managers should be from those with sufficient expertise, however we need to be careful to ensure that the support isn't too far to what is expected from peer support or first aiders. There

		needs to be a support network around first aiders, as it's not their job to carry the burden for the organisation. Mental health first aid is about normalising the conversation and not about delivering the psychological intervention - give organisation the language to be able communicate on this topic. **Group 4:** There was agreement that the two-pronged approaches seem to cover what is required and seems good. There is a huge area around training for managers – data around e-learning versus face to face might be interesting to see. Managers sometimes miss mandatory training if they are promoted inhouse. Feedback on this included: • Training here seems to be based on awareness training for mental health – the group expressed concern that management style, personal approach etc doesn't get taken into account in the scope. Management style however can make or break an individual and poor HR support doesn't help. • Maybe the person overseeing the process in organisation needs to be outside of the team – impartial – external audit. • In large organisations the lack of consistent training is huge – whose responsibility is it for the whole organisation? • The content of training that we should look at includes: spotting signs of poor mental wellbeing, self-care of manager.

		Outside of those areas listed the group suggested that we need to include management skills to avoid these problems – the key driver is job quality. It was stated that the problem comes from not recruiting the right people and that an open culture and leadership from the top are needed. Additional training and recruiting right people to the organisational values are important. Lots of levels need to be considered as new staff and existing staff in large organisation will need very different things. Beyond training for managers - this needs to filter through to all staff around identifying good mental health: identifying when things aren't quite right, what channels are in place, how do they signpost? The complete role for all employees – not just managers – should be thought about throughout the whole organisation. The group felt that: • Everyone should have basic training – then more targeted advance training for specific areas and concerns (minority arears) in a two tier approach. • Mental Health at Work - gateway to host lots of resources (hub of provider neutral resources) should be referenced as source of training. • The driver is productivity and perhaps the emphasis can change in the scope. Managers aren't measured on how nice they are or supportive of staff – it's about productivity. This is a big area for consideration.

1 Why the update is needed (Policy, legislation, regulation and commissioning)	3. A lot of different work is going on relating to this broad topic of mental wellbeing at work. What do stakeholders think it is important for us to focus on? a) Where are the gaps that this guidance should look to address? b) What are the key developments in policy and practice in the last 10 years since the guideline was published that we need to consider?	**Group 1:** Gaps in current guidance were identified including • How to support employees within an organisation and through one to one support. • Training around mental health awareness and developing a relationship with individuals. • Looking at everything altogether, such as . linking wellbeing to physical and mental wellbeing at work. • People with mental health conditions/symptoms that will impact on them in the workplace – there is a need for managers to have knowledge of a broader range of symptoms. • Support for employees to have the incentive and confidence to come to managers with health conditions, as disclosing this might impact on one's job. Building a good employer-employee relationship was thought to be important. **Group 3:** The group suggested developments that we could refer to or consider: • HSE work on what a wellbeing strategy looks like. This will be a useful link to be provided. • CIPD- great deal of research and work in this area

		• MIND have been active in this area • Faculty of public health/Health education England- guidelines and quality standards for public mental health, has tools that can be used. • Thrive London/West Midlands The group suggested that the new generation of children who are coming into the workplace should be considered, as social media may introduce more stress into the workplace. We need to consider the changing workplace such as homeworking, and how this gives the concept of the lonely, remote worker. Need to change management style to support people who are not in the same physical location. For SMEs, it is very hard for them to provide the support and signposting. The Mental health at work gateway are great resources designed to target SMEs. NICE need to ensure that any guidance is to the point and not too lengthy/needs to cut through the noise. **Group 4:** There is a gap around how we measure mental wellbeing – very useful to understand the ways in which we measure, what reporting standards are in place. Factors to consider could be around:

		• retiring early • people openly talking about wellbeing. • Measuring training and drop out may be important. This has always been an issue but now is in the spotlight. The conclusion of the Blue Light programme might also overlap with this guideline. Staff shortages and retention is hugely important as absenteeism factors highly, needs to be thought through and likely to be brought up when we consider resource impact. The group suggested that this will be a very difficult area on a topic like this and will have been done at individual neutral levels. They suggested that the business case as well as human case needs to be considered. Gaps in stakeholders were felt to include: • Trade Union Congress • Council for work and health • Farming and agriculture

Prioritisation and challenges	4. If we identify that we have too much to cover within the resource available, which areas should be prioritised over others? a) Why is that? What are the factors that drive your thinking? b) Which areas are not a priority? c) What are the main challenges that we might encounter with this topic?	**Group 1:** There were mixed views within the group: It was suggested that we don't focus on SMEs because they will not be able to implement the recommendations. However, it was also suggested that NICE should still look to make recommendations to try and bring about change. It was suggested we should keep the focus on wellbeing and not mental illness and put the person at the centre of everything. However, it was also suggested that priority should be on support provided for people with a diagnosed condition. Where there is no expertise with organisations to deal with employees with mental health conditions, this can lead to them being forced out of a job. It was pointed out though that focussing on this might lose the greater proportion of people dealing with mental health problems without diagnosed conditions. **Group 3:** Cross-reference a recommendation to flexible working in other guideline (NG13). We need a proactive message on public mental health and what that means for the workplace, the training available, what small changes in practice, such as people having a voice in a big organisation can make a big difference. It is not just about signposting Tailored support for employees with a mental health condition: there was felt to be already really good support for this group - so this could

		be dropped and instead signposted. They are also probably already getting treatment. The emphasis does not capture organisational development and culture focuses on interventions for the individual. The scope needs to capture our values on how we recruit and how we engage staff and how we operate. The approaches to identify area (1) need to make sure it includes organisational and individual development. Other general points made included: • Good wellbeing needs to be about a core sense of awareness, using this language will get a different reaction from people. • Alignment of language is important e.g. the word stress with HSE language. Talk about emotional hazards, fear, rejection and mental wounds e.g depression, anxiety. There is a lot of misuse of words, need to make sure that NICE is in line with HSE language. • Guideline needs to engage senior managers to allow the discussions to begin with charities, board members etc. The focus is on the benefit returned not the cost of the investment. It is an incremental change in culture, this is not a quick fix, so need to tell organisations that they need to continually build. • Language is aimed at the workforce and separating employees and managers, there's no mention of senior managers and CEO's - we should be looking at everyone together and highlighting special groups. Who is the guideline for section

		should include supply chains (contractual employment), investors/owners, CEO's and employees. • We should look at ISO standards looking at engaging your supply chain. • Guidance needs to state that managers need to review all organisational policies so that there is a cohesive response to this **Group 4:** Supporting those who are already experiencing mental health issues should be a priority. The group noted that it is very difficult to separate out universal and tailored interventions. Looking at relationships and the difference in those relationships - society and how we look after each other – very difficult, but very important. Financial stress – massive factor – but this will again differ based on demographics. This is where the group felt that it becomes apparent that the universal approach is not going to work for all. We should focus on different groups that might be at risk – roles, culture, demographic differences. Different needs will need different approaches, but overall leadership and supporting health more broadly: NG13 focuses on this and perhaps we need to focus on the mental wellbeing here.

Committee constituency	5. Who do stakeholders think are essential to have representation from on the Public Health Advisory Committee (PHAC) in the development of this guideline and why? a) Have we missed any key roles or perspectives? b) Have we duplicated any skills or experiences? c) Which of the listed professionals should be topic experts i.e. attend all meetings or co-opted experts, I.e. attend some meetings?	**Group 1:** • Trade unions with mental health responsibility • Local enterprise partnership • voluntary sectors: lived experience lay member; voluntary lay member • line manager (middle manager) • academics in workplace health being/promotion • GPs, neuropsychologist **Group 2:** • Representatives from the staff side • Psychologist / therapist / specialist • Academics / researchers • Company or organisation that currently has best practice **Group 3:**

		• Co-opt someone with lived experience of suicide- ideally someone who has attempted suicide or experienced suicidal ideation. • Representative of SME/self-employed individual • Director of organisation/board member • Voluntary sector organisations that cover communities • Public mental health experience - with experience of interventions that work • Enforcement- legal aspect in terms of what goes on in court rooms /corporate manslaughter • Arts/culture representation (e.g. music therapist) **Group 4:** • Mental health first aider is too specific, may not be independent enough and covered under other posts. A mental health champion/ mind and body champions - someone who is involved in the understanding of wellbeing in the organisation - would be more appropriate. • Lived experience network – someone with this type of experience. Ground level experience (possibly covered by lay member) • Trade union organisation to bring in a business perspective

		• CIPD type person (they are looking at mental health at the moment) – HR representative comes with an organisational approach by the nature of this role. • How are small businesses being covered? Federation of Small Businesses? 60-% of population covered by SME Need to consider private, public, small and large and rural organisations

3.3 Activities, services or aspects of care (Key areas that will be covered)	6. We intend to look at a range of individual and organisational-level approaches to improve mental wellbeing. Are there any specific types of interventions that you think are important that we focus on?	**Group 1:** The group hoped that the guideline would direct people to evidence-based interventions. They noted that employers are encouraging workers to do mindfulness at work, and it is important to look at implementing mindfulness at work. Approaches that the group suggested were important included: • BT 'passport' at work. • Employee confidence at work. • Routine monitoring at work. • RAP wellness recovery REACTION employment plan • Peer support. Evidence on peer support is mixed and not clear. It was also suggested that we should not exclude flexible working as it should sit within this guideline. **Group 2:** The group suggested looking at better induction processes – how they are structured; and mental well-being focused induction processes. They queried if this would fall within universal interventions? The health passport is introduced at this point; and tools to support disclosure. But beyond that you need to then equip people to respond to and deal with those disclosures.

		Group 3: The group queried the question which pushes for solutions - instead they thought the focus should be on the design of the system to include different elements that are necessary from causal incident investigations, hierarchy, tools like EAP and how it all functions together. The group felt that guidance should be on the systemic elements rather than on the solution. Health and safety work act is elastic which is why there is difficulties - there are operational pressures which will change over time so need to ensure you have the tools to be able to cope with these stresses. Additional approaches were suggested by the group: • Cultural/arts- e.g cultural first aid kit which was downloadable for rehabilitation for brain injury- which could be adapted for mental health mindfulness/activities that can be done at home • People working with mentally ill and primary care staff are at more risk of poor mental health, so interventions to support these people. • Digital interventions were thought to be missing • Signposting • WIN intervention **Group 4:** The group commented that:

		• Mode of delivery is an important consideration. • Anything that may work for financial stress – key driver and massive part of someone's wellbeing. Financial planning consolation of debt, advice financial awareness. • Regarding the evidence behind mindfulness and resilience, it would be interesting to see the effectiveness of these approaches as these are becoming routinely offered. • Mental wellbeing should be part of appraisals. In the right supportive organisation this would be excellent but implementing this is dependent on individual organisations and structure. Need to have follow on support as well. • Through EAP: access to councillors – monitoring how quickly staff get back to work. Interventions need to be about easily accessible and available services, long waiting time to see EAP. Specific work in the area that may be useful to refer to includes: Norfolk and Norwich trust have done some work around this. Liverpool studies - POPPY and INDIGO studies are useful in what they are achieving and by covering all angles. Doncaster approach – a check list at end of day so that you can go home and relax. The group suggested a massive area is flexible working and remote working of individuals and managers – keeping an eye on staff if you are not in the office and can see signs. General update will be in NG13, but it is an area of concern that isn't going to drop through,

		interventions don’t work for people who are in isolation - we need to think carefully about how we incorporate this. Specific interventions that we could consider include: • General awareness education • Equipping to support peers • Equipping line managers • Interventions – monitoring and performing • Wellness action plans

3.3 Activities, services or aspects of care (Areas that will not be covered)	7. We propose to exclude workplace interventions that aim to increase physical activity unless the primary aim is to improve mental wellbeing e.g. interventions such as yoga and tai chi. We are proposing excluding interventions where the primary aim is to improve physical wellbeing (for example through promoting walking/ cycling to work, providing sit-stand desks), due to crossover with existing NICE guidelines PH13 physical activity at work and PH41 Walking and cycling. a) Do you agree with this approach? b) Can you foresee any difficulties or limitations with this?	**Group 1:** If the interventions have outcomes related to mental wellbeing, then it needs to be factored in regardless of whether the focus is on physical activity (see previous comments on need to link mental and physical health) **Group 2:** There was general agreement with this. **Group 3:** The group did not agree with the suggested approach. They noted that one intervention may have different benefits for different people e.g. walking may provide physical benefit for some but a mental benefit for others. The danger is that we are trying to separate it out - we need to have that parity of physical and mental health as they are linked together. We should highlight the links, you can't separate the two. Some people are engaging with the activity to become fit, but they might improve their mental health (and vice versa).
3.1 Who is the focus? (Groups that will be covered)	8. We have proposed including everyone aged 16 or over in employment, regardless of the nature of that employment (for example, full or part time; paid, unpaid or voluntary; permanent,	**Group 1:** It was suggested that people with long term health conditions should be a specific sub group that we will look at. Self employed is a challenging group because they might not take time off and the fit in with groups with greater stress. We should not exclude

	temporary or zero hours contracts). a) Do you agree with this approach? b) What about people who are self-employed? c) Are there any employees that you think will need specific consideration?	self-employed people. The difficulty is self-employed people being aware of the guideline **Group 2:** The group made some general comments on the section Who is the guideline for? • EAP employee assistance program – comes under membership organisations for businesses / or employers representatives? • They questioned why trade unions are in the first rather than second category? Within thriving report – key finding was that it needs to be multi-layered; trade unions need to take on more of a proactive, supportive role rather than crisis / event management. Some agreement that trade unions move up the list. It was agreed that membership organisations should become a primary focus rather than secondary. • Suggestion to remove line 22 in the scope – all below this section should also be primary focus. • In employers should we also mention board members and senior leadership (including trustees; school governors etc) because this wouldn't fall into senior managers? Managers can only do this if they are trained / equipped from highest level. Middle managers need the support and ability to do this, and this often comes from board and senior leadership. They queried why does it need to be work-related stress that leaves someone vulnerable – could it not say work and/or non-work-related. Is

		it the work that is contributing to the poor mental well-being? People experiencing stress, anxiety, depression; *and* in some instances this is caused by work. Why does there need to be a diagnosis? Rephrase to 'experiencing' throughout. The group were reassured by inclusion of people aged 16; they saw this as a positive, particularly as for many this is their first experience of the workplace and it is important they start off on the right foot. The group thought that it is important to include trauma exposed organisations or industries. Need to tackle trauma in an organisational context; identifying risk factors in the workplace rather than just responding to them. UK Psychological Trauma Society (UKPTS) published guidance for traumatic stress management in the workplace. E.g. palliative care nurses as potentially trauma exposed, call handlers; administrators in mental health teams. Need to expand beyond front line staff to those who hear difficult things; watch CCTV footage etc as part of their work. They are also not receiving clinical supervision. Line 28 – amend to say 'trauma exposed industries including secondary effects / secondary exposure to trauma' Work-related violence e.g. nurses, people working in bars late at night – occupational exposure to violence, aggression. People who are self-employed – where do we put them: put them somewhere within line 18-19. But questions over how do they access this? Overall agreement that they need to be included; but questions over how they access and use the guidance. Suggestion that they may link in with professional bodies.

		It was suggested that we need to ensure that we aren't just focusing on large, public sector organisations – think about people working in garages, small shops, etc. We should be conscious of small and medium enterprises. Do we need to a separate section for this? Is this a population or group to add as a subsection? There was also a suggestion that we should include something on the impact of menopause in the workplace. **Group 3:** There were mixed views in the group on this. Some suggested that students who have work placements should be included as they could be vulnerable to workplace pressures. It was suggested we should adopt HSE work which explains clearly which groups should be covered and covers students. Some queried why it is 16 years and not lower as there are young people that work. It was also suggested that we should include self-employed people.

3.2 Settings (Settings that will be covered)	9. We intend to include interventions delivered within any workplace setting, or outside the workplace where an employer has some involvement in the intervention. Employer involvement may include the planning, design, delivery, management or funding of an intervention. a) Do you agree with this approach? Can you envisage any disadvantages of it? b) How will the types of approaches that are typically available for employees vary in different organisations?	**Group 1:** The group agreed that in all interventions including online and digital ones, the employer should have some sort of involvement to be included here. There was discussion about whether to include referrals as interventions, as this is a complex area and we need to be clear what we intend to do. **Group 2:** The group had no further comments on this. **Group 3:** Overall they agreed with the approach. If the intervention affects that employer-employee, then it should be within scope. They suggested that we need to reflect HSE work about volunteer/ carer working.

3.6 Main outcomes	10. Are there any important outcomes that are missing, or any that should not be there? a) What are the most important mental wellbeing outcomes? b) What are the most important outcomes for employers?	**Group 1:** The group suggested we should consider measuring productivity and return on investment/ cost-effectiveness **Group 2:** There was a comment on the need for consistency in terminology; we should not use mental health and mental well-being interchangeably. Ensure the outcomes are not too specific– personal experience and meaning for the individual is very important (but difficult to capture in interventions). The group noted that it is difficult to know if the outcomes stated are appropriate because no detail has been given about the specific measures being used to assess this; broader issues about measuring specific constructs e.g. work-life balance. Important to know which tools have been used to capture these outcomes which will influence intervention outcomes / success. Possible outcomes to consider: • patient and public safety (particularly for nursing workforce; truck drivers etc); • workplace errors (e.g. not operating machinery effectively; medicine dosing) • eudemonic well-being

		• meaning • work purpose – we should look beyond simple measures of work satisfaction. **Group 3:** It was suggested that we need to measure attempts of suicide, ideation; performance indicators; how people feel in terms of being valued at work; resilience.