Understanding the conditions for successful mental health training for managers

T1124

Mental health training programmes and methods for line managers

Dr Sally Wilson, Senior Research Fellow, Institute for Employment Studies
Alex Martin, Research Officer, Institute for Employment Studies
Dr Kate Spiegelhalter, Research Officer, Institute for Employment Studies

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Executive Summary

Background and aims

RSSB has commissioned the Institute for Employment Studies (IES) to conduct a research project to find the best way to support the rail industry in providing mental health (MH) training for managers. There are knowledge gaps regarding the best training methods and the best topics to cover.

This report presents the findings of literature review undertaken by IES to address those gaps. The report also informs an evaluation that will compare the effects of different types of training with a control condition (no training at all).

Overview of the evidence base

Only a handful of relevant, high-quality evaluations from the UK (and none in a rail industry context) could be identified and their findings on the effectiveness of training are not compelling. The international evidence base adds to this, but it is unclear what aspects of training make a difference. Also the transferability of findings across international boundaries is uncertain, particularly where there are differences in culture and regulatory context.

An Australian study that has shown positive effects (Milligan-Saville, Tan, Gayed et al., 2014) stands alone in terms of its rigour and findings. The training comprised a four-hour, face-to-face session and was delivered to managers in a large fire and rescue service. Managers receiving the training reported improved confidence in communicating with their employees and an increased likelihood of contacting an employee suffering from mental illness or stress.

Recommendations and observations

What are the best mental health and wellbeing topics to teach to line managers?

Topics for mental health training

Core	Line manager role	First response skills
(1) Awareness of mental health (in relation to self as well as others). (2) Communication skills (having conversations about mental health)	(3) Supporting mental wellbeing through managing workplace risks (4) Managing absence, return to work and making workplace adjustments	(5) Responding appropriately to signs and symptoms (in direct reports)

The review identified some themes common to effective courses and drew on authoritative sources of guidance to make recommendations. The table above presents the main themes and topics that mental health training for line managers should cover.

What are the best methods available to train line managers in mental health and wellbeing?

Some generic features of training courses that have been highlighted as successful include:

- Providing opportunities for interaction with other learners
- Using real-life experiences to illustrate points, for example:
  - personal accounts of real employees who have struggled with their mental health (such as on video)
  - case studies showing how particular situations were managed at work
- Tailoring content as far as possible to participants' sector or job roles

Concluding comments

We view that two, alternative main types of comparison would provide a useful addition to the current evidence base:

- e-learning vs. face-to-face administration (vs., no training); or
- MH first aid (MHFA) specifically for line managers[1] vs. mental health awareness specifically for line managers (vs. no training).

We recommend that the training is provided by an expert source, with the capacity to deliver in at least four locations in Great Britain. Ideally this would be an established provider capable of scaling up should the evaluation show a particular type of training is suitable for further roll-out.

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[1] At the time of reporting it was unclear whether a MHFA course for managers was available in the UK.

Background and aims

The research described in this report comprises the first part of a two-part project that is being undertaken to understand the conditions for successful mental health training for managers in the rail industry. The first part comprises a brief overview of the literature on mental health training, scoping existing and planned mental health training in the rail sector. The second part will be a study to compare two mental health training programme formats to ascertain the effectiveness of each relative to a control condition.

This report brings together findings from Part 1 and draws from these to outline an approach to Part 2 and make recommendations for the types of training to be evaluated. A final report will summarise the findings of the project as a whole, and detail the most appropriate training methods and courses, and the reasons why these work. This will include a full account of the final method for Part 2.

1   Overview of rail industry context

Research has shown that stress and mental health are the leading causes of long-term absences in the rail industry (ORR, 2018). This mirrors trends across the UK; the Centre for Mental Health estimates that a total of 72 million days are lost each year due to mental health issues, costing employers an estimated £35 billion per year (Centre for Mental Health, 2017). The CMH also estimates that effective strategies could reduce this substantially – one of the strategies listed is awareness training along with effective rehabilitation – potentially saving employers up to £8 billion per year (Centre for Mental Health, 2007).

The report 'Costs of impaired health across the network' (RSSB 2014) provides a strong business case for greater mental health and wellbeing support in the industry, which found that 1.06m days per year are lost to sickness in the industry due to ill health in general. Rail companies are now investing more in the area of mental health training. There is increasing acceptance that there is no 'one-size fits all' MH training and that different sectors - and roles within those sectors - need different approaches. In terms of role, line managers and supervisors are key targets for training as they arguably represent the front line of wellbeing management and act a gatekeeper to referrals or other pathways to support. MH awareness training can empower managers to approach mental health more effectively, with the potential to impact positively on their direct reports. Managers are also in position to address (or report) work stressors that can compromise mental wellbeing. An RSSB Knowledge search recently set out the importance of giving mental health training to line managers, and equipping them with the skills they need to identify, discuss and effectively deal with any issues employees may have. Furthermore, the knowledge search concluded, line managers can '*lead by example, raise awareness, promote dialogue, tailor job design, and create an open*

environment around mental health' once they themselves have a good understanding the subject.

2 Factors to consider when providing training

Effectiveness of any chosen media and method depends on subject matter, preferred learning style of individuals, and logistics of training delivery. Technology offers alternatives to traditional classroom training in the form of webinars, podcasts or videos. Site-based or peripatetic (rather than office-based) workers may need to be trained remotely. Accessibility is a consideration and technologically innovative training has to be accessible (internet access is not universal), and compatible with company hardware and software and security settings (firewalls). Ideally both audio and visual methods should be used to accommodate personal preferences and learning disabilities (such as dyslexia).

Mental health is an emotive subject that triggers issues for some; and there can be advantages and disadvantages to a classroom environment. However, learning in a group can be motivating and normalises the learning experience, and interactive methods can be helpful when shifting mind-sets.

Cost is inevitably a consideration; however, the opportunity cost of not providing training is a major factor. Quantifying the benefits of wellbeing interventions is always difficult, as cost savings can take a long time to become apparent. Moreover some individuals may not have the opportunity to apply new skills and knowledge until some time after training, and they may have forgotten elements.

If a given programme is shown to be effective, an ongoing process is ideal. All knowledge needs to become embedded and refresher training can be helpful to prevent skills fade. Also a 'train the trainer' model can be effective to disseminate knowledge provided there is adequate quality assurance of the process: measures would need to be in place to ensure content and delivery remained consistent across different trainers and settings.

Above all, the training must be suited to its audience. In wide-ranging academic review Hanisch, Birner, Oberhauser et al. (2016) suggested that there is potential for tailored workplace-based interventions to be a more effective route to engender a change in mental health stigma than other (more generic) means such as public campaigns.

3 Format of IES's research

RSSB commissioned IES to conduct a research project with the aim of finding the best way to support the rail industry to provide training in this area, specifically targeting mental health training for managers. There are knowledge gaps about:

- the best methods to train line managers
- the best topics to train line managers in
- how to understand and measure the beneficial impacts created
- how to support the costs of providing training
- how to maintain ongoing training activity within the rail industry.

At the moment, more evidence is needed to ensure that any training provided is of high quality. The primary outcome of this research will be clear, evidence- based recommendations for mental health training for managers in the rail industry.

This report details the findings of Part 1, a literature review looking into:

- mental health training programmes and methods used within the railway industry and comparable industries
- any outcomes of mental health training
- particular sorts of mental health training that have proven particularly efficient in improving employee outcomes.

The aim of Part 1 has been to consolidate the relevant mental health and wellbeing training activities in industry and outline the most appropriate method to carry out the outcomes study in Part 2. Part 2 will be an outcomes study, which will look at the specific outcomes in mental health of health training in at least 2 cohorts (department or team) compared to a control cohort (department or team without any training)

The objectives of this project as a whole are to answer these questions:

- What are the best methods available to train line managers in mental health and wellbeing?
- What are the best mental health and wellbeing topics to teach to line managers?
- How do rail companies measure the beneficial impacts created through the training?
- What is the most appropriate way to support the costs of providing training?
- What is the most appropriate way to maintain ongoing training activity within rail (training enough staff, re-training, knowledge retention)?

For RSSB the success of the work will be indicated by:

- The benefits of mental health and wellbeing training for line managers are expressly clear to decision makers within rail companies.
- These benefits stand up to scrutiny and will hold validity for some time.

- The most appropriate way to train and record the benefits of training is clear to railway organisations.

- The cost benefits of training provision for the identified training packages are clearly defined and compared to the savings made through training.

- Recommendations can be made to industry on the value and potential market structure for health and wellbeing training.

- Two or more training packages have been supported into action to train managers on health and wellbeing within rail companies.

- Learning has been obtained on the most effective training formats which can be transferred to other training initiatives within the rail industry.

A full discussion of how the project objectives have been met and a review of the extent to which the success criteria have been addressed will be provided in IES's final reporting output which will be prepared on completion of Part 2 of the investigation.

Approach to this review

The current review focussed on training to improve line manager awareness of mental health issues, and associated attitudes and behaviours. This scope of the work as specified by RSSB is shown in Table 1.

Table 1: Current and previous mental health interventions for line managers in the rail industry (Source: RSSB)

In scope	Out of scope
• All RSSB members (GB rail company staff) • Training that can be conducted for a majority of line managers • Training on health risks • Wellbeing training • Absence management training • Mental health training	• Fitness for work training • Railway training for health professionals • Non RSSB members • Training that could not be undertaken by a majority of line managers • 'Resilience training'

The IES review team searched PubMed, MEDLINE, PsycINFO, Cochrane, IBSS, JSTOR, Business Search Premier and Embase, with English language restrictions, from 2000 to 15 March, 2018, with search terms including 'manager*','supervisor', 'train*' and 'mental health'. The search terms in full are shown in Appendix A (a separate document).

Following a sift using titles and abstracts the search identified 23 relevant documents. A flow chart in Appendix B shows this process together with sift criteria. To capture training in comparable industries, four further academic papers were identified via personal contacts of the IES research team.

A data extraction matrix was used for the final step of the reviewing process: column headings of the matrix are shown in Figure 1 of Appendix A to this report to demonstrate how this was done. A new row of the matrix was added each time a paper was reviewed and relevant information was extracted following scrutiny and critical appraisal of the contents.

A search of grey literature proceeded in a more ad hoc way, informed by a current, landscape review being led by RAND Europe on 'Promising practices for health and

wellbeing at work'[2] and also a web search to explore whether any evaluations of known interventions had been reported outside the academic literature.

2 Michael Whitmore, Katherine Stewart, Jack Pollard, Janna van Belle,

Miaoqing Yang, Christian van Stolk (unpublished draft supplied by Stephen Bevan, advisor to the review)

Description of interventions in the railways sector

This section provides a summary of mental health training interventions for line managers that are known to have taken place in the rail industry. It also draws together findings from diverse sources which allow some assessment of their effectiveness.

4 Current and previous mental health training interventions for line managers in the rail industry

An early objective was to ensure that the IES team had a good understanding of current and historical mental health training provision in the rail industry and evidence for its effectiveness. After first checking that no relevant academic papers had been published (we present findings from the academic literature search in the next chapter) this involved searching for and studying 'grey' sources.

4.1 Documentation of interventions

To provide a starting point for the work, IES compiled a summary of recent and existing training packages applied in the GB rail industry. RSSB personnel were able to use their networks to get relevant information not currently in the public domain and were therefore instrumental to the creation of the comprehensive list shown in Table 2.

Table 2:   Current and previous mental health interventions
for line managers in the rail industry (Source: RSSB)

Name of training	Provider	Used by	Evaluated?
Building employee resilience	Resilient People	CrossCountry Northern Virgin	No records identified of rigorous evaluation
Leadership Training in MH Promotion	Run in-house	Siemens	No records identified of rigorous evaluation
Mental health Awareness e-learning (generic)	Mind	Virgin Trains (plans in place to pilot this)	No records identified of rigorous evaluation with follow up
Mental Health Awareness for Line Managers	Mind	Network Rail	Yes, but not in the rail industry
Mental Health First Aid	MHFA	Skanska Network Rail	Yes, but not in the rail industry

		London North Western	
		Western	
		Transport for London	
		London	
		National Grid	
Mental Health in the Workplace for Managers (MH4M)	Rethink Mental Health	Crossrail Virgin Trains	Yes, but not in the rail industry
Mental Health Management	Developed with support of RSSB. Currently run in-house	TPE	No records identified of rigorous evaluation
Mental health e-learning for Managers	'Feeling First Class' (developed in house)	Royal Mail	Yes, but not in the public domain
Stress Management & Resilience Training (SMART)	Sixth Sense consulting	Siemens	No records identified of rigorous evaluation

None of the training implemented in the rail industry at present appears to have been evaluated in that setting, using a rigorous methodology with a control group and medium-term follow-up. No rigorous, high-quality evaluations could be found in related sectors in the UK, such as construction, transport or manufacturing.

4.2 Evidence of effectiveness outside the rail industry

In the absence of evaluations conducted in the rail industry, the next step involved searching for evaluations of identified training in other industries. IES conducted a web search (via Google and Google Scholar) using training titles (those listed in the first column of Table 2) as primary search terms.

4.2.1 Rethink training

Rethink, a large UK mental health charity, offer Mental Health in the Workplace for Managers (half or full day versions) among a range of other courses, including

accredited Mental Health First Aid training. A 'snapshot' evaluation[3] (industry and sampling frame unspecified) showed 98% of line managers thought they would apply the knowledge and skills they had learned in their work. There was no follow up research to establish whether this occurred in practise or whether learning was sustained.

4.2.2   Mind training

Mind, another large national mental health charity offer face-to-face training for line managers and will tailor courses to meet specific industry needs. No evaluation of their training has been carried out to date in the rail industry or related sectors. IES recently evaluated Mind's 'Blue Light' line manager training for emergency services staff (Wilson, Sinclair, Huxley et al., 2016). The materials were highly rated and, at three months post-training, improvements in knowledge and confidence to address mental health issues were sustained. The generalizability of these findings to other contexts is uncertain because of the specialist focus of the Blue Light initiative.

4.2.3   Mental Health First Aid training

Mental Health First Aid (MHFA) training has been described as a way to '*promote early help-seeking, by equipping participants with the knowledge and skills to provide the initial help to someone developing a mental health problem or experiencing a mental health crisis before appropriate professional help is found*'. The MHFA curriculum is drawn from guidelines developed using the '*expert consensus of mental health professionals, consumers and carer advocates from developed English-speaking countries*' (Bovopoulos, Dorm and Bond et al., 2016).

The Mental Health First Aid website (MHFA, 2018) indicates that it has been widely applied in the UK, although the extent to which it has been delivered to line managers is unclear. The training is administered by accredited instructors and is now a well-established brand name. A key feature of MHFA is its focus on first response. It has been described as '*diagnostically led*' (Moffitt, Bostock and Cave, 2014), and uses video clips, presentation slides and learning exercises.

The authors suggested that the workplace relationship between the mental health first aider and the recipient is important: there is '*potential overlap and conflicts with performance management and concerns around workplace discrimination on the basis of mental health status*'. They also highlight '*the complexity of risks and potential conflicts of interest involved in helping people at different levels in the workplace hierarchy*'.

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3 Documentation supplied by RSSB, although the document did not make reference to the rail industry.

The issue of whether line managers are well placed to deliver mental health first aid is a very important one and possibly explains why it features in only a small number of studies that examine line manager mental health training reviewed in this report. This issue is discussed further in Section 5.

The wider evidence base

This section describes studies identified in the academic literature search which addressed the effectiveness of line manager mental health training in a multisector, international context. Appendix B provides a comprehensive summary of metrics used to evaluate training. Appendix C provides a guide to the quality of the studies.

5   Quality of the evidence base

Before investing in training, particularly on a large scale, employers need to know of its effectiveness and, where possible, its impact in business terms.

In a guidance paper focusing on the HSE Management Standards, as a basis of manager training (Shuttleworth, 2004), Shuttleworth (2004) highlighted the importance of conducting evaluations and, in particular, of looking at HR metrics such as performance and absenteeism. However, other authors (such as Dewa, Burke, Hardaker et al., 2006) have commented on the general lack of evaluations of training programmes that address mental health issues. Similarly Milligan-Saville, Tan, Gayed et al. (2017) noted that '*randomised controlled trials of manager mental health training on objective occupational and public health outcomes are scarce*'.

Gayed, Milligan-Saville, Nicholas et al. (2018) recently published a review of workplace interventions for managers, with an emphasis on the mental health of their direct reports. Only ten controlled trials met their requirements for the review. A meta-analysis showed good evidence of the effectiveness of these interventions with respect to improvements in manager knowledge and supportive behaviour. The evidence for employee outcomes was less compelling: aggregation of findings failed to show significant effects upon employee symptoms. The authors have recommended that more employee data needs to be collected to understand the benefits of line manager training on employees.

Before considering this body of literature further, consider that only one study has been highlighted in the recent Farmer and Stevenson (2017) report, 'Thriving at Work', as providing evidence for the cost-effectiveness of line manager training, namely that of Milligan-Saville et al. (2017). The fact that this was published a matter of months ago signifies the relative newness of this research area and the need for more evidence.

Table 3 shows how the reviewed studies break down when objective quality criteria are applied. The key point is the low number of randomised controlled trials (RCT) published in peer-reviewed journals. For clarity, these are flagged as such in the descriptions provided below.

Table 3: Table 2 Breakdown of reviewed studies by type of publication and study design.

Type of	Study design	Number of studies
Peer review	RCTs	9
	Evaluation not using RCTs	7
Grey literature	Not RCTs	7

This table does not represent the full extent of literature reviewed for the current report. Studies meeting relevance criteria were used to provide contextual information for this report. These included literature reviews, evidence based critiques and discussions of line manager mental health training.

6 Studies conducted within the UK

Given that HSE's influential Management Standards originated in the UK, and this country's relatively advanced understanding of occupational health, the national evidence base on mental health training for managers is small. It is not characterised by robust methodologies and generally does not include detailed scrutiny of course content with respect to suitability for line managers. The small number of reviews allows each to be discussed in some depth.

6.1 Mindful Employer

A Mindful Employer intervention which involved a variety of initiatives, one of which was line manager training (this is not described in detail) was rolled out in two SME settings in the Leeds region. An evaluation was conducted of the intervention as a whole, and did not distinguish between the impacts of the component interventions (Fryer and Kenvyn 2017). A comparison between pre-training and ten-month follow-up responses found positive changes in managers' self-reporting:

- comfort in discussing mental health with successful job applicants
- knowledge of how to respond to employee disclosure
- awareness of where to go for additional support
- confidence in their ability to recognise signs of employee distress.

The authors observed that ten months was a short interval within which to find all potential impacts; there was likely to be a continuing 'ripple-effect' within both organisations as the Mindful Employer interventions became assimilated into custom and practice. They suggested that this effect could potentially result in greater retention of the most able staff, reputational benefits from being identified as a 'good' employer, and that early intervention might mitigate against employees having a major health crisis that takes them out of the workplace for a protracted period, thereby reducing sickness absence.

Because this was an organisation-wide intervention, there was no control group; additionally, the positive effects described could not be wholly attributed to the training. Nevertheless it is interesting to note the relatively long period of time after the training that new information was retained.

6.2 Bespoke e-learning programme

A UK study evaluating 'GEM' e-learning for line managers in the NHS found that the intervention had a very small effect on employee well-being and little effect on sickness absence. However, the authors concluded that the study design was not powerful enough statistically to conclude this definitively (Stansfeld, Kerry, Chandola et al., 2015). They also suggested that the three-month interval between the end of the intervention and follow-up with employees was too short to allow managers to implement organisational changes likely to lead to changes in employee well-being.

This study contained some potential lessons about course length and organisational commitment. The course comprised six modules of up to 30 minutes each released over a three-month training period. Only half of the 41 managers completed a minimum three of the six main e-learning modules that were required to qualify as 'adherent'. Accompanying qualitative research indicated that managers did not have sufficient time to engage with the intervention, and a lack of senior management buy-in was reported, drawing attention to some of the realities of rolling out training for time-pressured staff.

6.3 Mental Health First Aid training

Brandling and McKenna (2010) evaluated Mental Health First Aid (MHFA) training that was delivered to line managers in three different public sector organisations in Wiltshire. A three-week follow-up study showed a significant positive change in level of knowledge and confidence. Data from the qualitative interviews was thematically analysed, and six themes were identified: supporting one another, stigma and attitude change, increased knowledge, facilitation, course applicability, and research participation.

The authors concluded that MHFA was able to increase knowledge and confidence of the participants in relation to mental health. However, impacts on their approach to management were not directly investigated. Also there were no control group studies to

use as a comparator. Another question not addressed was whether the training (which did not have line manager in the title) had the right fit with the line manager role. Background information provided in the paper suggests that the decision to roll-out this training may have been influenced by the likelihood of those managers encountering not just members of their own staff who need MHFA, but also members of the public.

6.4 MHFA vs. bespoke line manager training (Fire Service)

To assess the suitability of MHFA relative to training developed especially for line managers, Moffitt, Bostock and Cave (2014) evaluated the impact on managers of three mental health promotion interventions:

- a locally developed course entitled 'Looking after Wellbeing at Work' (LWW), which lasted two days
- an internationally developed training course: Mental Health First Aid (MHFA), which also lasted two days
- an hour-long leaflet session (LS).

The 'Looking after Wellbeing at Work' (LWW) course emphasised the business cases for promoting wellbeing, the responsibilities of managers, and ways that organisational sources of stress could be addressed collectively. It also demonstrated methods for dealing with personal stress and the stress of colleagues or direct reports. It was developed with the Fire Service in mind and used relevant case studies.

The 'control' condition consisted of a one-hour briefing session, during which participants were invited to view and read over leaflets around stress, mental health, and physical health.

Managers were grouped by role (watch manager, control room officer, senior manager), then randomly allocated to three conditions to ensure an equal spread of managerial grades across the following groups: Looking after Wellbeing at Work training (LWW), Mental Health First Aid Training (MHFA), and a leaflet session. Participants completed pre-training, post-training and a three month follow-up questionnaire.

Notably MHFA performed similarly against locally developed training. Compared with the leaflet session, the LWW and MHFA courses were both associated with statistically significant improvements in attitudes towards mental illness and knowledge/self-efficacy around mental health. Nevertheless, the study was unusual in its direct comparison of two different types of training, one that was termed 'a diagnostic approach' while the other had a 'wellbeing orientation'. The authors suggested that different outcomes may have been observed if they had looked at organisational management of stress and/or wellbeing outcomes: possibly the measures used for were not sensitive to the differences between the two courses.

7 International interventions

The inclusion of international studies enables analysis of a broader range of interventions but does not significantly increase the evidence base. Again, the small size of the evidence base allows this report to assess each study individually.

7.1 Germany

A single day of manager training was provided in a large industrial company in Germany (Boysen, Schiller, Mörtl et al., 2018). This encouraged manager self-awareness of their own mental states (including resilience-building), and also improved communication skills and ability to deal with signs of distress in employees. There was also a component on company-specific 'legal' procedures for addressing mental health at work. As well as classroom-style instruction the day included interactive lectures and intensive group discussion. The evaluation focused on changes in manager wellbeing rather than the wellbeing of people they managed; preliminary analyses showed positive changes in scores of managers' mental health after three months.

This was a preliminary study and the authors state that '*given this study was conducted in a non-randomised and uncontrolled design, it is not possible to clearly ascribe these improvements to the training*'.

7.2 Australia

An RCT was carried out to evaluate a mixed-approach intervention that combined multi-session leadership coaching for the senior officers in police stations with tailored mental health literacy training for lower and upper ranks (LaMontagne, Milner, Allisey et al., 2016). This included a 360 degree leadership assessment for station leaders followed by a one-hour 'feedback and development' session, designed using the UK HSE Management Standards in combination with CIPD guidelines. Despite the intensity of the intervention, a 12-month follow-up study showed no effects (LaMontagne, 2017). Lack of success was attributed to operational duties being prioritised over planned training activities and an insufficient number of officers completing the course.

A relatively modest intervention used in the Australian fire service produced much more compelling results. Milligan-Saville, Tan, Gayed et al. (2017) conducted a cluster randomised controlled trial of manager mental health training within a large fire and rescue service, with a six-month follow-up. Managers (clusters) at the level of duty commander or equivalent were randomly assigned to either a four-hour face-to-face RESPECT mental health training programme or a deferred training control group. Fire-fighters and station officers who were supervised by each manager were included in the study via their anonymised sickness absence records.

Managers' knowledge of their role in regard to dealing with employees on sickness absence was tested; additionally, mental health knowledge was assessed with a series of

true-or-false questions about mental disorders. A modified stigma scale of previously published measures was used to measure stigmatising attitudes (Greenberg Gould, Langston et al., 2009; Griffiths, Crisp, Jorm et al., 2011; Griffiths, Christensen, Jorm et al., 2004). Confidence in communicating with employees on sickness absence was assessed by presenting managers with various situations and asking them to rate their level of confidence in dealing with it.

Managers receiving the training reported improved confidence in communicating with their employees and an increased likelihood of contacting an employee suffering from mental illness or stress. At the six-month follow-up, the intervention and control groups did not differ from each other in scores for mental health knowledge, non-stigmatising attitudes towards mental illness, or knowledge of a manager's role regarding sickness absence. However, the mean improvement in baseline confidence when communicating with employees regarding mental illness and sickness absence remained, and was significantly greater in the intervention group than it was in the control.

The **RESPECT** principles are:

Regular contact is essential

the **E**arlier the better;

Supportive and empathetic communication

Practical help, not psychotherapy

Encourage help-seeking

Consider return to work options

Tell them the door is always open and arrange next contact.

In the eight weeks following the RESPECT training, a representative from an employee assistance programme telephoned managers in the intervention group, to answer any outstanding questions.

At the point of the six-month follow-up, the mean rate of work-related sick leave had decreased in the intervention group and increased in the control group. The difference attributed to the intervention was equated to a reduction of 6·45 hours of sickness absence per employee every six months, with an associated return on investment of £9.98 for each pound spent on the training.

Gayed, Bryan, Petrie et al. (2018) have recently reported on an RCT called HeadCoach, but not on its results. HeadCoach is an online training intervention aimed at improving manager support for individuals experiencing mental ill health, and promoting manager behaviour associated with a mentally healthy workplace. The target sample comprises 168 managers, plus their direct employees. Outcomes will be explored at a four-month follow up. The primary area of interest is a change from baseline in managers' self-reported confidence when dealing with mental health issues within their team and

promoting a mentally healthy workplace. The follow-up will assess employee outcomes in relation to a perceived level of manager support, engagement, psychological distress, and rates of sickness absence and presenteeism.

As highlighted at the beginning of this chapter, the Australian study that has shown positive effects (Milligan-Saville et al., 2017) stands alone in terms of its rigour and findings. Milligan-Saville et al. (2017) have commented that '*this cluster randomised controlled trial shows, for the first time to our knowledge, that simple mental health training for managers in the workplace can generate meaningful public health and individual benefits*'.

7.3 Canada

A Canadian study describes a one-day workshop that was developed to teach managers to identify and respond effectively to employees with mental health problems (Dewa, Burke, Hardaker et al., 2007). The study focused on identifying the elements of the training that were seen as most helpful (Section 5 provides details of these findings).

Dimoff, Kelloway and Burnstein (2016) reported on the development and evaluation of a three-hour training programme designed to increase mental health literacy among managers. In accordance with the Mental Health Commission of Canada's recommendations regarding effective mental health interventions (2012), the training content was also designed primarily around three areas:

- early identification and recognition
- early and appropriate engagement
- assessment, planning and monitoring.

The authors conducted two studies with an RCT design, one in a university and the other in a telecommunications company. In the first study, with university leaders, managers who received the training reported enhanced knowledge of, and attitudes toward, mental health, as well as increased self-efficacy and intent to promote mental health at work. These effects were replicated in Study 2, with indirect effects on attitudes and intentions also reported. Analysis of management data over a nine-month follow-up period showed a reduction in the duration of short-term mental health disability claims; the authors therefore suggested that the programme had brought significant cost-saving to the organisation.

It is difficult to interpret what this reduction in disability claims would mean in a UK context; for example, whether it would result in shorter durations of sickness absence and/or greater or fewer numbers of staff becoming unwell. The large Canadian organisation concerned was reportedly '*experiencing rising costs associated with short and long-term mental health disability*', so it may have been a special case and the general applicability of these findings is uncertain.

7.4 Japan

Several RCTs have been run in Japan to test manager training interventions. Most have been run by the same team and have yielded inconsistent outcomes. The findings are reported in Table 10 in Appendix B. Also the transferability of the findings to a UK context is uncertain.

An RCT run in a computer engineering company investigated the effects of a web-based training package that focused on worksite mental health, job stressors, supervisor support and psychological distress among subordinates (Kawakami, Kobayashi and Takao, 2005). The average time to complete the entire training was between three and five hours. Over the three-month follow-up period, perceptions of supervisor support were maintained for subordinates of the intervention group but decreased significantly for subordinates of the control group. A second, similar study in a sales and service company failed to show any significant effect on job stressors in subordinate workers (Kawakami, Takao and Kobayashi, 2006).

Tsutsumi, Takao, Mineyama et al. (2005) tested a face-to-face intervention of less than a day, comprising:

- a lecture on supervisor roles in MH practices based on national guidelines
- a short lecture on active listening focusing on how to advise supervisees.

The authors found significant improvement in knowledge for departments where more than one-third of supervisors attended training. Also, self-reported stress decreased for employees in departments where more than one-third of supervisors attended training. The strength of their conclusions was limited by experimental constraints that meant participants were not randomly assigned to the control condition.

Takao, Tsutsumi, Nishiuchi et al. (2006) investigated the effects of training on '*positive mental health in the workplace*' for managers, comprising a single face-to-face session. An RCT design was used. The aim was to reduce mental distress and improve performance in people they managed. Follow-up observations three months after the training found these aims were achieved for only one group of workers (young male, white collar).

In another RCT, Nishiuchi, Tsutsumi, Takeo et al. (2007) assessed the effects of a four-hour, face-to-face job stress reduction programme for managers in a brewery, which promoted positive workplace mental health and support to employees in distress. This found marginally significant improvement in knowledge and self-reported behaviour among trainee managers compared to the intervention group.

A different research group (Ikegami, Tahara, and Yamada, 2010) studied the impact of mental health training for managers in a large Japanese manufacturing company (course duration was 200 hours in total). The programme, which involved interactive face-to-

face learning, addressed active listening, stress reactions, social support of workers and mental health-related sick leave. Job stressors were assessed by an employee questionnaire and were shown to have decreased, while rates of sickness absence improved in the three-year monitoring period. However, the lack of a control group limits the certainty that improvements resulted from the intervention.

More recently Yoshikawa, Ogami and Takashi (2013) evaluated a workshop-based mental health training programme for supervisors in the insurance and finance industry, centring on the implementation of a Mental Health Action Checklist. A follow-up survey carried out six months after the training revealed that many feasible and concrete measures had been taken. These included '*thorough provision of information*', '*improvement of working space*' and '*provision of opportunities for on-the job training*'. The evaluation did not look at the secondary effects upon the wider workforce or address wellbeing outcomes. Also no control group was used to allow any between-group comparison.

When the Japanese studies are viewed collectively, they do not indicate a straightforward relationship between the time participants are required to invest in training and the nature of the outcome. However, and pertinent to the current study, these findings do suggest that face-to face and e-learning courses lasting less than a day can be effective.

8   Factors determining effectiveness of reviewed interventions

Unsurprisingly, studies that have looked for immediate knowledge gains following training have found them, almost without exception. Other gains, such as improved manager confidence, have also been reported in most cases. Sustained learning outcomes have been identified in most cases where study follow-up occurred, although follow-up periods have varied in length from three weeks to two years.

Where studies have failed to find positive effects of training, authors have generally cited the appeal of the intervention rather than its specific content or approach. Interventions which make significant demands on time, especially when they require management staff to be taken away from operational duties, have the potential to fail for logistical reasons. A programme for senior Australian police sergeants is a case in point: poor attendance was felt to have compromised results (LaMontagne, 2017).

The ensuing sections of this report directly address RSSB's research questions about training interventions. Since this report summarises Part 1 of a two-part project – the latter involving primary research – we anticipate being able to address these questions more comprehensively at the final reporting stage.

Interim conclusions and observations

This section of the report directly addresses the research questions the project as a whole has been designed to answer. Some can only be addressed partially at this stage and Part 2 of the project will inform these further.

9 What are the best mental health and wellbeing topics to teach to line managers? Interim conclusions and observations

In the absence of research evidence satisfactorily addressing this question, this section takes a pragmatic approach. Below, we draw out themes common to many of the courses identified through our review and consider these with respect to recommendations from statutory sources of advice (such as NICE and HSE). We then consider implications for RSSB's training evaluation.

9.1 Indications from the research evidence

The evidence base assembled here does not indicate which content is most effective when training line managers on mental health because, in general, the studies we reviewed did not set out to gain an understanding of what type of content worked best. Only one of the reviewed studies (Moffitt, Bostock and Cave, 2014) contrasted training courses with different types of content, and it found both to be effective.

Another way of considering this research question is to ask which course achieved the best results. A standout high quality paper study from the review was a recent RCT that tested the effectiveness of the Australian 'RESPECT' course (Milligan-Saville, Tan, Gayed et al. 2017). This showed that training was associated with a statistically significant drop in absence rates, with compelling consequences for return on investment. Although there is no way of determining which features of its content brought about positive changes, it is worth noting that the content is practically-oriented and, according to its developers (Harvey, Barnes, Milligan-Saville et al., 2017), includes:

- key features and impacts of common mental health issues in the workplace
- roles and responsibilities of senior officers in the recognition and management of mental health issues
- developing effective communication and management skills.

A training needs analysis, which was conducted to inform course development in Australia, is potentially useful to consider[4] (Shann, Martin and Chester, 2014). However, it yielded rather generic and arguably predictable findings. The elements of training that leaders (managers) reported as having been useful were:

- workplace strategies for responding to mental health conditions
- identifying and understanding mental health conditions
- information about services and resources
- provision of case studies and examples.

An obvious flaw in asking participants about the content of a course they have attended is that they rarely have a point of comparison and are unlikely to be able to reflect in an informed way on what else should have been included. Expert perspectives, as described below, can therefore offer more nuanced insight.

9.2 Additional considerations

A further difficulty of evaluating course content from the research literature is that training content that works well for one audience may not be appropriate for another. A particular consideration is national context: guidance should be compatible with national standards and regulatory frameworks, such as those concerning disability, health and safety and employee rights more broadly. Among the UK training interventions described in the review of academic papers, only one makes explicit reference to national guidance: the 'GEM' training described by Stansfeld, Kerry, Chandola et al. (2014), which was based on HSE's Management Standards.

Cultural factors also affect the suitability of courses; for example, stigma and misapprehensions about mental health conditions vary according to national context. Context for occupational groups is also relevant to consider, and a key aim for the current project is to identify the approach that is best suited to rail workers.

Finally, it is important to bear in mind that the course content is not always made transparent for commercial reasons (in academic papers as well as publicly accessible sources). This can mean that the credibility of the organisation delivering or developing a course (such as national mental health charities and/or occupational health experts) is the most reliable available indication of quality of content.

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4 Among the small proportion of managers who had participated in training related to managing mental health in the workplace, the majority had participated in Mental Health First Aid and beyondblue. The study was conducted in Australia where these training providers are (originally) based.

9.3 Common themes in line manager training

Some common themes emerge when considering the learning objectives of the training considered in this review. The basic and more obvious aims of improved mental health literacy and communication are common to all courses. These can be viewed as underpinning other competencies with respect to managing and supporting employees, with respect to the line manager role and first response skills, which are more variably represented. This is set out in Table 4.

Table 4:   Recommended topics for line manager training

Core	Line manager role	First response skills
1. Awareness of and knowledge about mental health ('mental health literacy')	3. Supporting mental wellbeing through managing workplace risks	5. Responding appropriately to signs and symptoms
2. Communication skills (having conversations about mental health, handling disclosure)	4. Managing absence and return to work	

This section draws out these common themes, referencing authoritative UK sources of guidance where applicable.

9.3.1   Awareness of mental health

All of the reviewed training has aimed to increase the knowledge bases of the participants regarding mental wellbeing, while also attempting to develop what is often termed **'**mental health literacy'. The UK organisation Business in the Community (BITC, 2016) has been prescriptive about what this means and has highlighted the importance of the message '*we all have mental health*' (at any one time a person's mental health is on a spectrum ranging from unwell to well) and tackling what can be 'a culture of silence'.

9.3.2   Communication skills

Another pervasive theme is good communication, specifically with respect to the navigation of potentially 'difficult' conversations that can arise with respect to mental health and wellbeing. The recent independent review for the UK Government entitled 'Thriving at Work' (Farmer and Stevenson, 2017) advises that '*line managers are well trained to have practical and engaging conversations with employees*'. Clearly this skill is compatible with effective line management more generally and is consistent with the idea that having good 'people skills' is an advantage when dealing with any potentially emotive circumstances at work.

9.3.3   Supporting mental wellbeing through the management of workplace risks

The majority of courses address work-related stress, and the risks workplace pressures can present to mental health and wellbeing. Training would be expected to highlight the role that line managers can play in supporting healthy working cultures and practices. This component aligns with a preventive or 'primary' approach to occupational health (as described by LaMontagne, Martin, Page et al., 2014). In a UK context it would be

advised that training content includes HSE's Management Standards (as in the case of training described by Stansfeld, Kerry and Chandola, 2015).

An independent review by IES for NICE concluded that '*line managers have an important role in protecting and improving the health and wellbeing of their employees*' and that managers should be given '*adequate time, training, and resources to ensure they balance the aims of the organisation with concern for the health and wellbeing of their employees*' (Hillage, 2015). In short, training for line managers should focus on their role in the maintenance of good mental wellbeing in their team, as well as the need to react when things go wrong.

9.3.4   Responding appropriately to signs and symptoms

Knowledge of signs and symptoms (enabled by mental health literacy) can help managers to recognise when a worker is in need of support and respond in a proportionate, informed way. In 'Thriving at Work', Farmer and Stevenson observed that line managers '*lack the training, skills or confidence required to effectively support others at a very basic level*.' NICE recommend that line managers are given training '*in how to recognise and support employees when they are experiencing stress*' (NICE, 2017), but do not specify precisely what should be included in course content. They advise that managers and supervisors receive training '*to be confident in spotting signs of distress, ensuring their own behaviours are positive and dealing with problems as early as possible*'.

A 'first response' competency forms a strong emphasis of Mental Health First Aid (MHFA) training, but research indicates some potential issues for recipients of this training in a line manager role. Bovopoulos, Jorm, Bond et al. (2014) conducted an expert panel study which highlighted '*additional considerations where the person assisting is a supervisor or manager, or is assisting in crisis situations such as acute distress*'. The authors suggested that the workplace relationship between the mental health first aider and the recipient could result in '*potential overlaps and conflicts with performance management*' and '*concerns around workplace discrimination on the basis of mental health status*'. They highlighted '*the complexity of risks and potential conflicts of interest involved in helping people at different levels in the workplace hierarchy*', essentially questioning whether line managers are the right people to deliver MFHA.

The concerns set out above would suggest that training in first response for line managers needs to be delivered with the demands of their role in mind: in such a way as to help line managers understand how they can balance the performance management responsibilities of their role with more pastoral aspects.

It is apparent that this topic should be included in line manager training, but needs an approach that is tailored to the line manager role. It is relevant to consider that MHFA

England is currently developing a bespoke training package for line managers, but details about this were not yet available at the time of the current review.[5]

9.3.5 Managing absence, managing return to work and making workplace adjustments

Some formal processes in relation to managing mental health at work are specific to the line manager role. In particular their contribution to tasks that may involve working with HR professionals; such as managing absence, making OH referrals and implementing workplace adjustments. Current NICE guidelines have recommended that line managers receive training in absence management, but CIPD recently concluded that many line managers are ill-prepared to do this (CIPD, 2016). HSE recommends training line managers in managing sickness absence and return to work (HSE, 2004).

Absence management features in most, but not all, of the training courses reviewed for this report. This is potentially more difficult to deliver as an off-the-shelf training product; procedural aspects of the line manager role may be tied to internal HR policies, potentially requiring a bespoke approach from course providers.

Given that reduced absence is a desirable outcome of mental health training, it is clear that the content should include absence management and other procedural aspects of line management concerned with mental wellbeing. Within the context of training for RSSB members, this would need the content to be sufficiently generic to apply to a wide range of companies and modes of working.

9.4 Recommendations on topics to include in the training to be evaluated in Part 2

It is helpful to view the five topics we describe above as falling into three main categories. Table 5 differentiates between: 'core' competencies (those one might expect any training course on this topic to include); those specific to the line manager role, and those concerned with an effective first response. This is not intended to be an exhaustive list, or to imply that each should necessarily be given equal weight.

We recommend *all* five topics are included in any training that RSSB commissions for the evaluation. One potential evaluation design could involve comparing training courses with different combinations of the topics, but metrics would have to be chosen (and interpreted) very carefully in these circumstances so as not to bias results. Another possible option is to compare training products which include very similar content but are delivered with a variation in style and emphasis. This raises the possibility of offering

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5 As indicated by correspondence between an RSSB representative and MHFA England

two training providers the 'syllabus' in Table 4 and comparing the outcomes of training products they produce to this specification.

[Move Table 5 to here?]

10 What are the best methods available to train line managers in mental health and wellbeing?

As with the question about topics, the review does not answer this definitively. Some observations from the literature are considered below before suggestions from the evaluation are made.

10.1 Indications from the research evidence

The research evidence does not provide any certainty about the most effective training methods as this was not usually the central area of interest. Most evaluations were of face-to-face training (classroom style training or workshops) while a few looked at e-learning and/or online learning. None set out to compare the two.

Reflecting on the academic literature, of the four studies most highly rated for relevance and quality, three showed successful results for face-to-face training, while one showed marginal effects for e-learning. There is no way of determining whether they would have achieved different results with those populations using other methods.

In general, researchers have not discussed methods of course administration, even though it could be a determinant of participation and/or success for some learners. In considering this issue, Dewa, Burke, Hardaker et al. (2006) suggested that it could be useful to establish '*whether different methods of communicating similar information may be needed for those who are more reticent to changing their attitudes or to learning about mental illness*'.

10.2 Provision of opportunities for interaction with other learners

Russell, Berney and Stansfeld (2016) conducted a qualitative study of an intervention which offered experiential learning as well as an online element. Interviews and group discussions with managers showed that the opportunity for interaction with other learners was felt to be an important component of learning.

In a Canadian study of manager training (Dewa, Trojanowski, Joosen et al., 2017) more than 200 workshop participants who completed an evaluation form were asked what

aspect they valued the most. Responses were diverse but nearly one in five indicated that they most valued '*interaction with fellow participants and instructor*'.

Clearly, face-to-face formats allow two-way interaction much more readily than training that is solely provided via electronic media. In some work environments there may be opportunities for participants to discuss issues raised by the e-learning with others subsequent to the training (or between modules). However this is not feasible in the circumstance of managers being trained who do not routinely work together.

10.3   Examples of 'real-life' experiences

Dewa et al., (2017) reported that around 14% of trainees indicated they valued video content above all other forms of presentation. The majority of positive comments on this topic referred to the videos that offered personal accounts of real employees who had struggled with their mental health. Among respondents, 18% asked for more specific examples of employee accommodations and discussions of real-life case studies.

In an evaluation of MHFA, training video clips were described as 'informative' and 'powerful', with participants commenting on the way the video clips brought things to life and provided real life experience of the issues (Borrill, 2010).

Russell et al. (2016) raised a related point about real-world applicability. They found that, for most managers, the key value of the training was not the acquisition of new knowledge but the way in which it backed up existing knowledge, and encouraged reflection on managerial practice.

A tailored approach will usually be helpful to ensure that participants find training relevant. For example the bespoke course described by Moffitt, Bostock and Cave (2014) was designed with the Fire Service in mind and used relevant case studies and role-play.

A potential challenge for the proposed evaluation will be the mix of roles and specialisms among the training participants drawn from the rail industry. An example that is judged as 'relatable' for one individual may be viewed as irrelevant or alien to another.

10.4   E-learning that is not overly burdensome

There are some clear merits of web-based training compared with traditional lectures and workshops, and these have been described by Kawakami, Takao, Kobayashi et al. (2006):

- Participants do not have to attend lectures together, which sometimes results in a significant reduction of time on the job and considerable expenses in travelling to the training site.
- Web-based training provides greater flexibility for participants, in that supervisors can access the training at their own pace and at any time they like.

- Participants may repeat the lessons as many times as needed.

- The progress made by participants can be monitored centrally.

The flexibility offered by online learning is also its potential downfall. A major risk with self-directed e-learning appears to be adherence. Stansfeld, Kerry, Standola et al. (2015) found that more than half of participants failed to complete more than three of six e-learning modules (the authors did not state the time commitment of each in hours).

If e-learning is introduced in the planned evaluation, some thought should be applied to adherence. To help minimise non-completion, the time commitment should not be overly-burdensome and ideally the course should be user-friendly and engaging. The offer of some type of meaningful accreditation at the end of it could provide an incentive for completion.

10.5 Recommendations on best methods to include in training that is undergoing evaluation in Part 2

The literature considered in this review shows a research gap in this area, which RSSB's evaluation could go some way towards addressing. This would mean delivering very similar training in completely different formats and comparing the outcomes. The obvious candidates for this are face-to-face classroom training and e-learning. It should be feasible to include all of the topics identified in the last section in each, depending on the flexibility of the selected training provider(s). Ideally, elements that have been shown to work well should be included in one or both of these, namely videos with real-life examples relevant to mental health, and opportunities for interactive learning.

11 How do rail companies measure the beneficial impacts created through the training?

This section draws out the implications of this review's findings for IES's proposed use of metrics in Part 2.

11.1 Choice of metrics to compare different training types

For all types of workplace wellbeing training there are numerous potential indicators of success, ranging from take-up to health-related outcomes. Table 10 in Appendix B summarises the wide array of metrics that have been used in the sources that IES has reviewed.

Our interpretation of the literature is consistent with IES's original scoping of metrics in our proposal, where we suggested suitable metrics and the likelihood of detecting effects if these were applied. Our original analysis,suggests additional effects that could

potentially be detected over a longer timescale, should RSSB decide to support a longitudinal study, involving additional data and analysis. These are shown in the left-hand column of Table 5.

With the timeframe in mind for IES's evaluation, we advise looking at outcomes concerned with acceptability of the training to trainees' knowledge, confidence and (self-reported) behaviours. This approach would allow impacts of training to be assessed in greater depth than has occurred previously in the rail industry, although findings would be confined to line manager participants. Future long-term analysis could enable further reaching (sometimes termed secondary or tertiary) outcomes to be assessed, that concern the wellbeing and productivity of the wider workforce and bottom line business impacts.

Table 5: Potential metrics of interest in success of mental health training

Level	Metrics	Likelihood of detectible effects in current study timeframe	Likelihood of detectable effects in longitudinal study
Individual level, line manager (trainee)	Training participation/attendance	High	High
	Views (on quality of training)	High	High
	Awareness of mental health	High	High
	Attitude/perceptions of stigma	Medium	High
	Knowledge and knowledge retention	High	Medium
	Confidence to tackle	High	High
	Management behaviours with staff who have/are at risk of MH problems	Medium	High
	Own mental wellbeing/self-management of mental wellbeing	Medium	High
Industry or company level	Productivity	Low	Medium
	Sickness absence	Low	Medium
	Mental wellbeing of all staff (average)	Low	Medium
	Presenteeism	Low	Medium
	Engagement	Low	Medium
	Health outcomes among wider staff	Low	Medium
	Costs to rail companies	Low	Medium
	Staff turnover	Low	Medium

11.2 Sensitivity/specificity

Moffitt, Bostock and Cave failed to find any significant differences between a local bespoke intervention and MHFA training, and suggested that their own measures may have lacked sensitivity. This recommendation underlines the importance of choosing metrics that can potentially differentiate between levels of achievement in training

topics and sub-topics. For example if one type of training has a strong focus on communicating with workers while the comparator does not, then it is important to include measures more sensitive than, for example, 'do you feel more confident talking about mental health?' The inclusion of ratings scales rather than 'yes' or 'no' options is one way of addressing sensitivity.

11.3   Time frame of follow-up

RSSB has indicated an intention to continue measuring impacts of the training over a longer timeframe than the planned Part 2 evaluation. Desirable changes of behaviour among line managers would be expected, eventually, to result in improved wellbeing among those they manage, leading to fewer occurrences of sickness absence.

One approach to looking at this involves comparing absence in the treatment groups before and after the training (among direct reports of managers, not the managers themselves). Another requires the comparison of absence rates in the treatment groups after the training with absence rates in the control group over the same period. Ideally both types of comparison would take place to control for trends over time such as, for example, an overall improvement in wellbeing across the rail industry as a whole, or any changes to sick pay entitlement that affect behaviour across the board. The aims would be to isolate the impact of the intervention from other causes.

12   What is the most appropriate way to support the costs of providing training?

This is a challenging question to answer as the studies described in this report typically did not monetise the costs and benefits and training. Although training duration was usually reported the costs of developing and delivering that training were not.

We expect other elements of the research to shed more light on this, namely findings from the evaluation that address costs and benefits and a planned roundtable discussion with industry stakeholders. The latter will allow consultation on the kind of evidence and arguments that stakeholders need to build a business case to invest in this area.

IES will use available data to itemise costs of training procured for the upcoming evaluation. Costs arising from lost productivity during training attendance will also be estimated as accurately as available data allows.

A business case for mental health interventions is made by Farmer and Stevenson in Thriving at Work. They cite Deloitte estimates of the return on investment (RoI) of a range of workplace interventions to demonstrate the business case for investment. In Deloitte's report (Monitor Deloitte, 2017), the authors propose that 'proactive mental health support'; such as manager workshops (line manage training isn't explicitly mentioned) could deliver an RoI of six pounds for every pounds spent on that type of

intervention. Their calculations of RoI were made on the basis of data that Deloitte collected, together with a set of assumptions from other reports[6].

More specifically Farmer and Stevenson cited the recent study conducted by Milligan-Saville, Tan, Gayed et al. (2017) which showed that a mental health training programme for managers could lead to a significant reduction in work-related sickness absence, with an associated RoI of £9.98 for each pound spent on such training. This calculation was based on like-for-like costs of providing cover for absent staff (the direct reports of line managers involved in the study).

That no other training studies are cited in 'Thriving in Work', highlights the lack of empirical evidence in the area.

13 What is the most appropriate way to maintain ongoing training activity within rail?

The planned evaluation timetable allows learning outcomes to be followed up approximately three months after training delivery and will look at whether knowledge retention varies according to the type of training received. Findings from studies looking at learning retention indicate that it is realistic to expect training participants to recall knowledge after an interval of this scale.

There is no information in the reviewed literature about desirable gaps between training. There is also no information about optimum numbers to train or the viability of a 'train the trainer model' (which can be a cost-effective way of disseminating knowledge in an organisation). It is therefore important that the planned research addresses this by, for example, using interviews to explore preferred or optimal approaches to maintaining ongoing training activity.

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[6] The soundness of this evidence base has since been critiqued in the editorial of *Occupational Health at Work* (Ballard, 2017).

Final comments: Implications for the procurement of training to be evaluated in Part 2

This report is intended to provide a starting point for discussions about the interventions to be compared in Part 2. We consider that two main types of comparison would provide a useful addition to the current evidence base. Available resources for the Part 2 study would allow one of the two options below to be explored:

1. **E-learning vs. face-to-face administration** (vs. no training); this would represent an innovative approach to evaluating mental health training. That is, testing whether a relatively low-investment mode of training delivery is as effective as a more resource-intensive one. We recommend that both courses should cover topic areas 1 to 5 (see Table 4).

   or

2. **MH first aid (MHFA) for line managers vs. mental health awareness for line managers** (vs. no training); this would enable a course from a widely known brand, known for its focus on first response skills (see topic 5, Table 4), to be compared with a line manager course with a more 'generic' approach (ideally with an even coverage of topics 1 to 5).

Before deciding between these options we recommend that RSSB explores whether any MHFA courses are currently on the market which include topics 3 and 4, to ensure that any training being evaluated covers relevant aspects of the line manager role.

In addition we recommend that all training is provided by an expert source, with the capacity to deliver in at least four locations in Britain. Ideally this would be an established provider capable of scaling up should the evaluation show a particular type of training is suitable for further roll-out.

Apart from intentional differences to content or format, as many aspects of the training as possible should be similar. Stronger conclusions can be drawn if differences in outcome can be attributed to the main variables of interest rather than for example inconsistent quality or depth of training materials.

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