HEADS TOGETHER “MENTAL HEALTH FOR SMALL WORKPLACES” ONLINE TRAINING EVALUATION
FINAL REPORT

November 2019

CONTENTS

1 EXECUTIVE SUMMARY

Mind developed 'Mental Health for Small Workplaces' in recognition of the challenges that SMEs face in accessing tools and learning opportunities that support mental health in the workplace. The online training and resource library is provided free and aims to increase understanding, raise awareness and enable workplaces to create environments supportive to mental wellbeing.

1.1 Reach

Since launch in April 2019 to September 3,835 people had accessed the training. Of those, 1,327 (35%) completed all three modules, 1,986 (52%) were in progress and 522 (14%) had registered but not yet started.

Over a third (37%) of the users were in managerial or leadership roles, and together with HR professionals this group accounts for over half of all users. Survey responses indicate over half of users had direct experience of mental health problems, with over 40% having personal experience.

1.2 Accessibility and expectations

73% of survey respondents that had fully completed the training said it met their expectations. Users found the platform easy to navigate and the content informative and accessible. Content was easy to understand and provided an appropriate level of depth. Being produced by Mind gave confidence and engendered trust in the training.

1.3 Enablers and motivation

Most users were already aware of mental health problems and wanting to make changes to improve mental wellbeing. The training isn't in itself acting as the impetus for change, but provides the tools for organisations and individuals who already wanted to make change.

Our evidence indicates that employer commitment is an important enabler of training uptake and completion. The accessibility of the training also contributed to take up and completion. Increased awareness of mental wellbeing and personal interest motivated people to learn.

1.4 Outcomes and impact

The training was highly effective in increasing users' knowledge and confidence to recognise, understand and be able to support both themselves and their colleagues with mental health problems. Over 90% of respondents reported increased levels of knowledge and confidence after completion of the training.

Learning proved to be durable with over 70% of respondents four to six weeks later agreeing that the training had increased their confidence and understanding across all but one of the planned learning outcomes.

47% of respondents reported they had done something to support their colleagues' mental wellbeing at work with a further 30% of respondents planning to do something in future.

Changes that Individuals and organisations were already making included:

- more open discussion of mental wellbeing in the workplace
- individuals disclosing their mental health problems to colleagues
- speaking to a colleague about their mental health
- taking practical steps to improve wellbeing such as more frequent breaks and use of relaxation techniques
- organisations developing mental wellbeing strategies and policies
- cascading mental health training across organisations

Whilst it is still early days for many organisations there are indicators that changes made as a result of the training will have a positive impact both on organisational processes and, more importantly, cultures in the longer term.

2 INTRODUCTION

2.1 Background

Small and medium-sized enterprises (SMEs) account for 99% of the 5.5 million businesses in the UK and 60% of the private sector workforce. However, they can face unique barriers in accessing tools and support available to employees of larger companies in relation to supporting mental health in the workplace. There is often limited in-house support in this area and few opportunities for employees to undertake structured learning and development.

Mind developed 'Mental Health for Small Workplaces' in recognition of the challenges that SMEs face in accessing tools and learning opportunities that support mental health in the workplace. It has been funded through the Royal Foundation as part of the Heads Together campaign.

The online training and resource library is free and aims to:

- help employees in SMEs to understand and support mental wellbeing in the workplace
- increase awareness of mental health problems in the workplace
- help employees take action to look after and improve their own mental wellbeing

The training package contains three short modules, covering the following themes:

- building your awareness
- looking after yourself
- supporting each other

2.2 Purpose of evaluation

At the core of this evaluation was understanding the participant experience of accessing and using the online training, and evidencing whether the intended learning outcomes were being achieved. Furthermore, we attempted to understand what difference this was making in terms of behavioural change and what impact this might have on organisations. Finally, the evaluation also explored what difference that may make to people with mental health problems.

In summary we aimed to address the following questions:

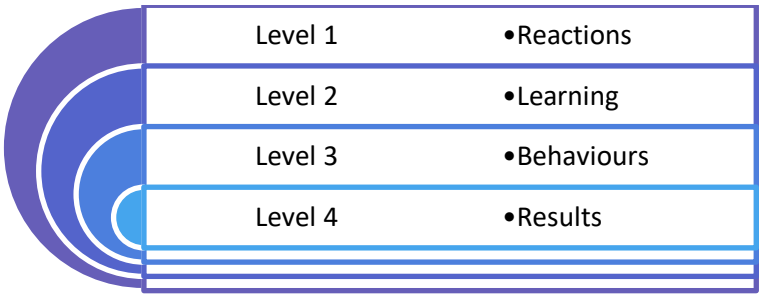
- who the training reached, and did not reach?
- how effective was the delivery method in landing key messages and generating the intended learning outcomes?
- what worked well about the training and what could work better?
- to what extent did participants gain the intended outcomes:
  - increased awareness of mental health and wellbeing in the workplace?
  - improved knowledge of where to find information and support around mental health and wellbeing in the workplace?
  - increased confidence to access support?
  - increased confidence to support a colleague?
- what difference did those outcomes make to individuals and organisations?
- what did people and organisations do differently as a result of the training?
- what difference might that make to people experiencing mental health problems?

3 METHODOLOGY

3.1 Approach

The methodology was underpinned using the Kirkpatrick model (shown below). This is a tried and tested model for evaluating training and development interventions, which examines the different levels of impact a learning intervention can have.

Figure1 – Kirkpatrick Model



3.2 Method

We designed the evaluation framework and tools to capture data at each of the levels of the Kirkpatrick model, as described briefly in the table below.

Figure 2 – Key lines of enquiry and tools for data capture

Level		Key lines of enquiry	Method/tool
1	Reaction	Are the conditions for learning right; what is enabling learning and what is getting in the way?	Post-module surveys Non-completers survey
2	Learning	What key learning from the programme has endured for the participants; which key concepts that have really 'landed' and influenced their ongoing practice?	Post-module surveys Follow-up surveys Telephone interviews
3	Behaviour	What are participants doing differently as a result of their learning, and what have been the enablers and barriers to doing so?	Post-module surveys Follow-up surveys Telephone interviews
4	Results	What impacts have these behavioural changes made on the individuals themselves, their colleagues and staff and their SME?	Telephone interviews Case studies

Post module surveys were embedded into the training platform and were made available at the end of each module for completion by participants. At registration, users were asked to opt in to receiving follow-up surveys and/or participating in a telephone interview.

The evaluation period was from the launch of the training, in mid-April, to October 2019.

3.3 Survey response rates

Response rates for the post module surveys have been good and so we can be very confident that the data is representative of all users with just a small margin of error, as indicated in the table below. Therefore, we can be very confident that the findings based on the data gathered are reliable and robust.

Figure 3 – Post module survey response rates

Module	Survey participants	Module completers	Participation rate	Margin error[1]
Building your awareness	**1,116**	**2,187**	**51%**	**2.1%**
Looking after yourself	**701**	**1,505**	**47%**	**2.7%**
Supporting each other	**642**	**1,546**	**42%**	**3.1%**

Follow-up surveys were sent to users four to six weeks following registration. Surveys were sent to those that had fully completed the training, those that were part way through and those that had registered but not yet started. Response rates for the follow-up survey are lower but overall, they have been good and we can still be very confident the data is representative of all users with a relatively small margin of error. So again, we can be reasonably confident that the findings drawn from this data are representative of the entire user population.

Figure 4 – Follow-up survey response rates

	Survey returns	Users with consent	Response Rate	Margin error[2]
Total	**365**	**2,099**	**17%**	**4.7%**
Completers	**175**	**596**	**29%**	**6.2%**
Partials	**123**	**970**	**13%**	**8.3%**
Not started	**67**	**533**	**13%**	**11.2%**

We carried out 52 telephone interviews. Of those interviewees, 32 had completed the training at the time their details were passed on to us. We also spoke to 20 partial completers, though again this was at the time contact details were provided and when we spoke to them a small number had actually completed the training.

3.4 Limitations

With this approach to data collection, where respondents self-select, there is a risk of bias in that only those with very positive or very negative feedback will complete the surveys. However, given the level of response rate for both post-module and follow-up surveys, we are confident that there is no significant positive bias, and the findings are a reliable representation of the users' experience and learning.

The main limitation with the evaluation was the time available in which to gather evidence at level 4 of the Kirkpatrick model - results or impact at organisational level. It is just too early to see evidence of change at this stage.

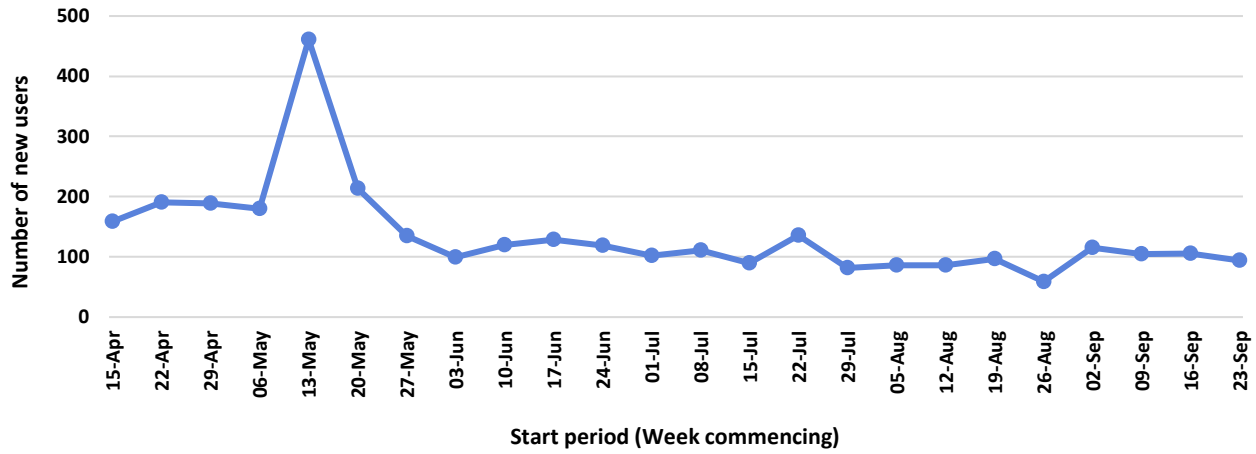
[1] Used http://www.raosoft.com/samplesize.html with 95% confidence level.
[2] Used http://www.raosoft.com/samplesize.html with 95% confidence level.

4 ACCESS AND REACH

By the end of the evaluation period, 1,327 people had completed the learning, a further 1,986 were in progress and 522 had registered but not yet started. While this fell short of the original targets of 5,500 starters and 2,750 completers it should be noted that the launch was delayed by eight months.

From launch on 16th April to the end of May 2019, the weekly average number of users starting the training ranged roughly between 150 and 200. Week commencing the 13th of May showed a considerable peak, of 461, which coincided with Mental Health Awareness Week. After May, new users averaged about 100 per week. This is demonstrated in Figure 5.

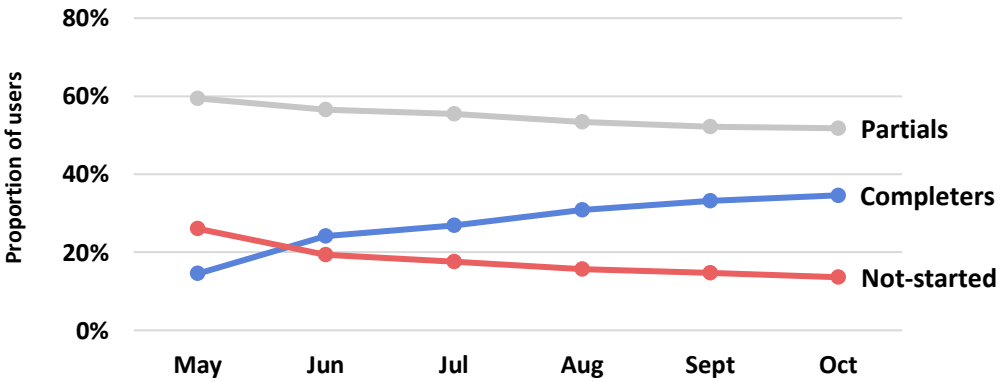
Figure 5 – The number of new users starting the course per week settled at around 100



It is always difficult to predict uptake of a new product, but it is encouraging that uptake has continued at a consistent level over time, and there is nothing to indicate this will decrease in the future. Furthermore, promotion for the product was fairly low key, and more proactive promotion could boost future uptake, as demonstrated by the peak during Mental Health Awareness Week.

Of all those that registered, 35% completed all three modules, whilst 52% started or completed at least one of the modules. However, it is worth noting that our interviews revealed that several of those that were recorded as partial completers had actually completed all three modules. Therefore, the actual proportion completing was higher than the figures recorded. Figure 6 below provides an overview of the proportions completing and partially completing the modules each month:

Figure 6 – Since launch, the proportion of users that only registered decreased consistently



4.1 Types of organisations accessing the training

The following section uses registration data to describe the types of organisations, sectors and regions the training is reaching.

Most users (88%) were employed in small (10-49 employees) or medium-sized (50-249 employees) organisations with only 12% working in micro organisations (fewer than 10 employees). This represents an underrepresentation for micro organisations, which actually employ a much higher proportion of the employees within the SME sector[3]. This may be indicative of the capacity of very small organisations, including sole traders, to take time out for training.

The training has reached all sectors but there has been a disproportionately high uptake within the Charity, not-for-profit and voluntary work sector, with 26% of users being in this type of organisation. This may reflect the cultures within these types of organisations, and perhaps greater awareness of the mental health agenda. It may also be, as some of our interviews indicated, that online, bite-sized training is particularly beneficial for these types of organisations, where resources and capacity are limited. In addition, interviewees from these organisations reported that they are often providing services and working with client groups that can be emotionally challenging for staff.

Education, training and childcare also had a high take up, accounting for 13% of all users. All other sectors accounted for between 1% and 6% of users.

Geographical uptake roughly matched the population breakdown[4]. However, it's noticeable that the most underrepresented regions are those outside England. The most underrepresented is Scotland, which had 4% of registrations despite accounting for about 8% of the population.

4.2 Types of people accessing the training

4.2.1 Role

The figure below shows that over a third (37%) of the users were in managerial or leadership roles, and together with HR professionals this group accounts for over half of all users. This is unlikely to be proportionate to the actual workforce but does reflect what we heard during interviews; interviewees in those roles were often exploring options for providing mental health training to share with employees, and/or developing strategies and policies to improve mental wellbeing in the workplace.

If all these managers cascaded the training out to their workforce, this could boost uptake considerably as the training makes it way out through the organisational structures.

[3] Sources suggest 36% (Merchant Savy https://www.merchantsavvy.co.uk/uk-sme-data-stats-charts/) and 54% (House of Commons Library https://researchbriefings.files.parliament.uk/documents/SN06152/SN06152.pdf). Note that these sources consider the private sector, not other organisations such as charities. This is under the assumption that the proportion of large companies that chose medium-sized is not significant.

[4] Population Estimates Total Persons for England and Wales and Regions, Office for National Statistics.

Figure 7 – Registered users by job role

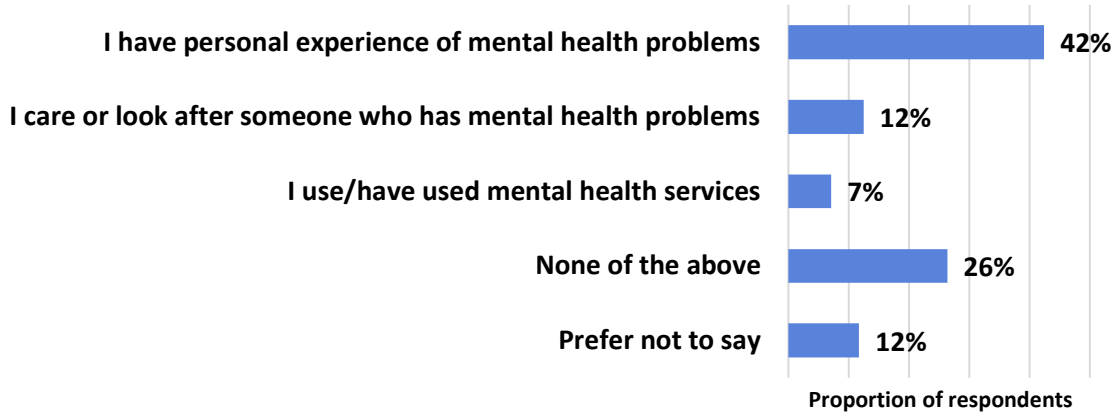
Job Role	Users	%
Employee	1,697	44%
HR professional	567	15%
Senior manager	551	14%
Line manager / supervisor	549	14%
CEO or leadership role	337	9%
Sole trader	69	2%
Volunteer	65	2%

The proportion of employees completing the course (54%) was higher than those in more senior roles (44%).

4.2.2 Experience of mental health problems

Responses from module 1 participants indicated that a high proportion had some first-hand experience with mental health problems

Figure 8 – Over half of the module 1 survey respondents reported having direct experience of mental health problems. With over 40% having personal experience of mental health problems



N=1,116

Our interviews bore this out, with several interviewees sharing their own experience of having had mental health problems, and having had a poor experience of this in the workplace.

4.2.3 Motivations for doing the training

More than half of respondents were looking for resources to help them improve organisational approaches to mental health. In addition, a high proportion wanted to learn how to support colleagues or themselves better.

Figure 9 – Key motivations for registering for the training were positive

These motivations were borne out in the interviews, with many seeking advice or support to make improvements, either to their own working life or the organisations they worked for.

Whilst nearly a third indicated it was a workplace initiative, only 8% indicated it was a request from their line manager that was motivating them. These findings indicate again very positive reasons for completing the training, compatible with our earlier findings of individuals being already interested in making changes and developing their own knowledge and confidence.

Looking at the main reasons for signing up, it is clear that users were already aware of mental health problems and wanting to make changes. In other words they were already in the contemplation or preparation phase of the change cycle. We didn't see (or hear in interviews) examples of the training itself acting the impetus for change.

4.2.4 The importance of employer commitment

As described in section 4.2.3 being asked to do the training by a line manager was not a motivating factor for the majority of respondents however the survey findings do indicate that employer commitment is an important enabler of training uptake and completion. Most respondents who completed the training had found out about it from a line manager (31%) or colleague (21%). Conversely 48% of responding non-completers had found out about the course themselves online, compared to 23% of completers. We can infer from this that, if the training opportunity is being shared or advocated by a work colleague, an individual is more likely to complete the training. Our interviews supported this, with examples of managers or other employees who actively encouraged colleagues to do the training following their own good experience.

5 REACTION TO THE TRAINING

Survey and interview feedback paints a positive picture of the way the training has been designed and delivered.

46% of survey respondents indicated the training met their expectations, and this rose to 73% of those that had fully completed the training. Overall, less than 1% said it did not meet their expectations, the remainder reported that they had started the training without any expectations.

5.1 Quality

Users found the platform easy to navigate and the content informative and accessible. They liked the blend of formats and levels of interaction. Written material was described as well presented, and most users found the videos engaging, with interviewees reporting that being able to hear from real people was an engaging way to learn. There was one comment that increased narration may help with accessibility. Whilst we would not always report isolated comments we do feel this is a valid point and worthy of consideration for further development.

There were very few negative comments from interviewees about the quality of the training and some stated that, as it was produced by Mind – a known and trusted organisation – they felt confident the content would be of a good quality, reliable and accurate.

5.2 Content

Respondents reported that the content was easy to understand and provided an appropriate level of depth, with the ability to go into the resources to get more information if they wanted. Some commented that the material was a bit basic, but these users came to the training with a higher level of knowledge and experience than most might have. Despite this, most still reported that the training had served as a useful refresher.

> "I thought it was really useful for them [staff] to take a minute to think about mental health… what constitutes stress, etc…. what it is, where to go for help, and also, if I remember, there is a section to how help a colleague"

Information in the resources section was revisited and shared, for example through organisations' intranets. 44% of respondents had used the resources with a further 49% indicating that they probably would in the future. We heard similar in interviews, where there were examples of resources being drawn on to inform company handbooks, and others reporting that it was useful to know the resources were there for future access.

After completion of a module, users were asked to identify the most and least useful elements of the training. The two most and least useful components for each module are highlighted in the table below.

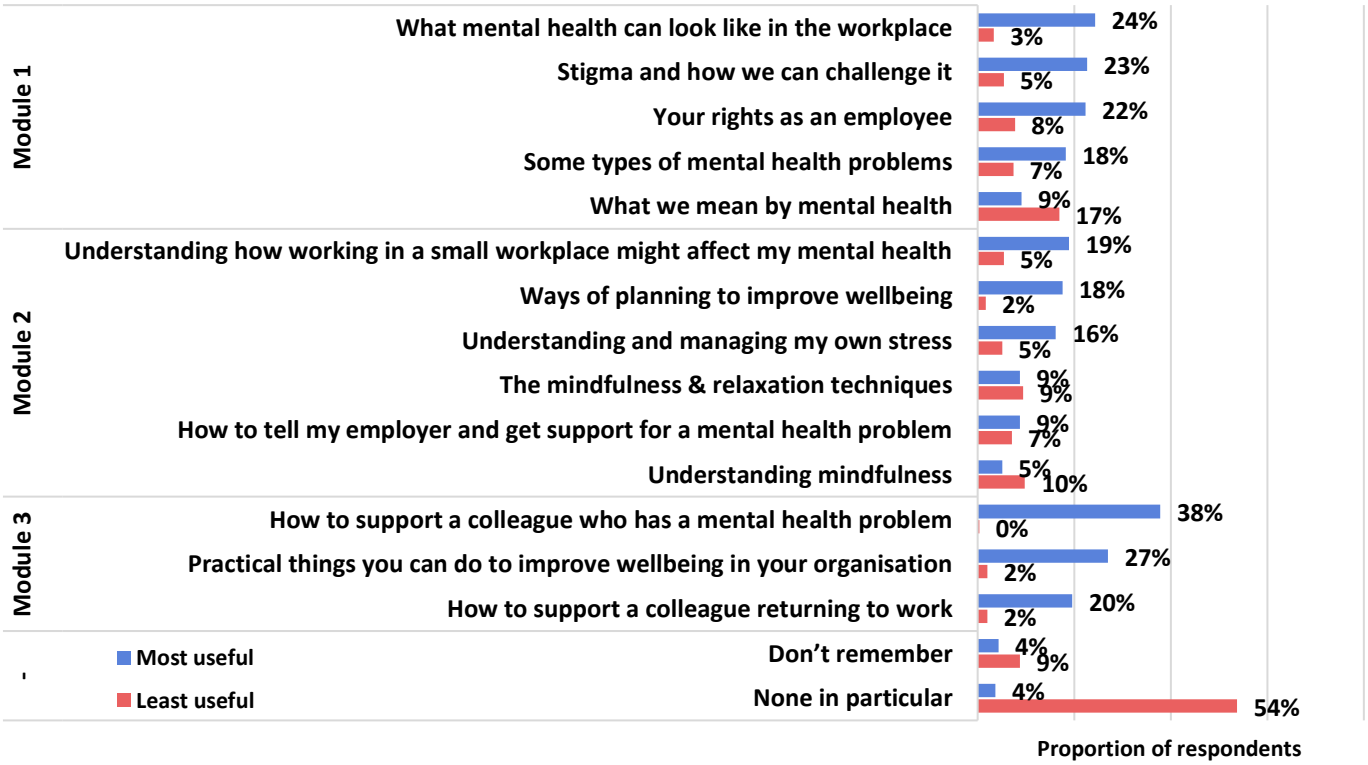
Figure 10 – Most and least useful elements of each module

Module		Most useful		Least useful
1	1	What mental health can look like in the workplace	1	What we mean by mental health
	2	Some types of mental health problems	2	Your rights as an employee
2	1	Ways of planning to improve my own wellbeing	1	How to tell my employer & get support with a mental health problem
	2	Understanding and managing my own stress	2	Understanding how working in a small workplace might affect my mental health
3 Non-line managers	1	How to support a colleague who has a mental health problem	1	What to do if you are a line manager
	2	How to have an effective conversation	2	Practical things you can do to improve wellbeing in your organisation
3 Line managers		Practical things you can do to improve wellbeing in your organisation		How to have an effective conversation
		How to have an effective conversation		Practical things you can do to improve wellbeing in your organisation

Interestingly line manager respondents found the same two elements both the most and least useful. Perhaps reflecting these areas are key skills for line managers, and that a reasonable proportion of line managers already feel competent in those areas.

In the follow-up survey, respondents were asked to reflect over the entire course, and responses suggest that module 3 was regarded as the most useful.

Figure 11 – Overall the units from module 3 were considered to be the most useful among respondents, and almost no respondents felt these were the least useful



N=296
Note: respondents were asked to tick two or three most and least useful

Whilst module 3 had a higher proportion of users selecting the units to be most useful (as well as the fewest finding them least useful), the other two modules were not significantly behind. Furthermore, over half of respondents reported that there were no modules/topics in particular that they found least useful. This is encouraging and suggests they took something away from each of the units/modules.

5.3 Barriers to completion

Though the training takes a relatively short time to complete[5], lack of time was still identified as the most significant barrier to completion. 53% of non-completers identified lack of time as the main barrier to completing the training, whilst half of completers reported being given dedicated time by their employer.

> "Work commitments make finding the time to complete the course difficult at this time"

Having a space to do the training was much less of an issue, although 12% reported not having enough space and completing it outside their workplace. One example of this was a team of care workers that were not office-based, spending their working day predominantly in the homes of those for whom they were providing care.

A small number or respondents reported IT issues as barriers. This included a variety of things from forgetting their password, to not being able to access required software such as YouTube. Several also commented that they had completed the training but were unable to get a certificate. This is likely to be due to a small omission along the way, which is frustrating for the learner and may be difficult to find when they go back to make sure they have covered all the points. It may be worth exploring with the e-learning provider.

5.4 Enablers

5.4.1 Employer role

As we have already alluded to, the role of the employer in promoting, encouraging and enabling completion, for example through protected learning time, seems important in maximising participation and – importantly – completion of the training. Helping to facilitate this through a dashboard, which would enable them to monitor participation and completion was one suggestion we received from a line manager, and one we would endorse from our experience of working with employers on health initiatives. This would enable them to target reminders to staff part way through which we think would push up completion rates. The surveys showed that most partial completers wanted and intended to finish the training, so a prompt may help nudge them in that direction. Our interviews supported this finding, with some saying the interview had prompted then to go back to the training.

[5] Estimated completion time is about 20 minutes per module, therefore about an hour in total. https://www.mentalhealthatwork.org.uk/resource/mental-health-for-small-workplaces-elearning/?read=more

"It was shared to the whole organisation. It's up to staff what to do with it, when to do it, but we are encouraged to do it."

5.4.2 Peer recommendation

Linked to this, anecdotal feedback from interviewees suggested that it can take just one person in the organisation to complete the training and recommend it to their colleagues for participation to spread. The recommendation of a trusted peer can be a powerful motivator for others.

5.4.3 Self-motivation and public awareness

As already discussed, many users had a genuine interest in mental health, both their own and that of others, and were already seeking information and opportunities to learn more. The mental health agenda continues to grow, with greater awareness and recognition of its importance, which was reflected in feedback during our interviews. As discussion and interest grows within society, this should increase the appetite for more learning and training opportunities.

"Mental health at the workplace is something high on people's agenda at the moment, (sharing the link) is another way to support the team if they wanted it."

5.4.4 Online and bite-sized

Whilst the findings suggest that time and IT have presented challenges to completing the training, conversely these two things were reported by most of those interviewed as being key enablers. Being online and delivered in bite-sized chunks meant that users had flexibility in terms of when they completed the different modules. We heard that, if the training required them to physically attend a course, this would create a greater barrier than having it delivered in this way.

5.4.5 Cost (or lack thereof)

Several interviewees acknowledged that budgets for training and development were limited, and that this training being free was critical in their participation. Others mentioned that if there was a cost it may have reduced the number of people in the organisation who would have been able to benefit.

"It really looked great. I was amazed by it and that it could be free."

6 WHAT DIFFERENCE IS IT MAKING?

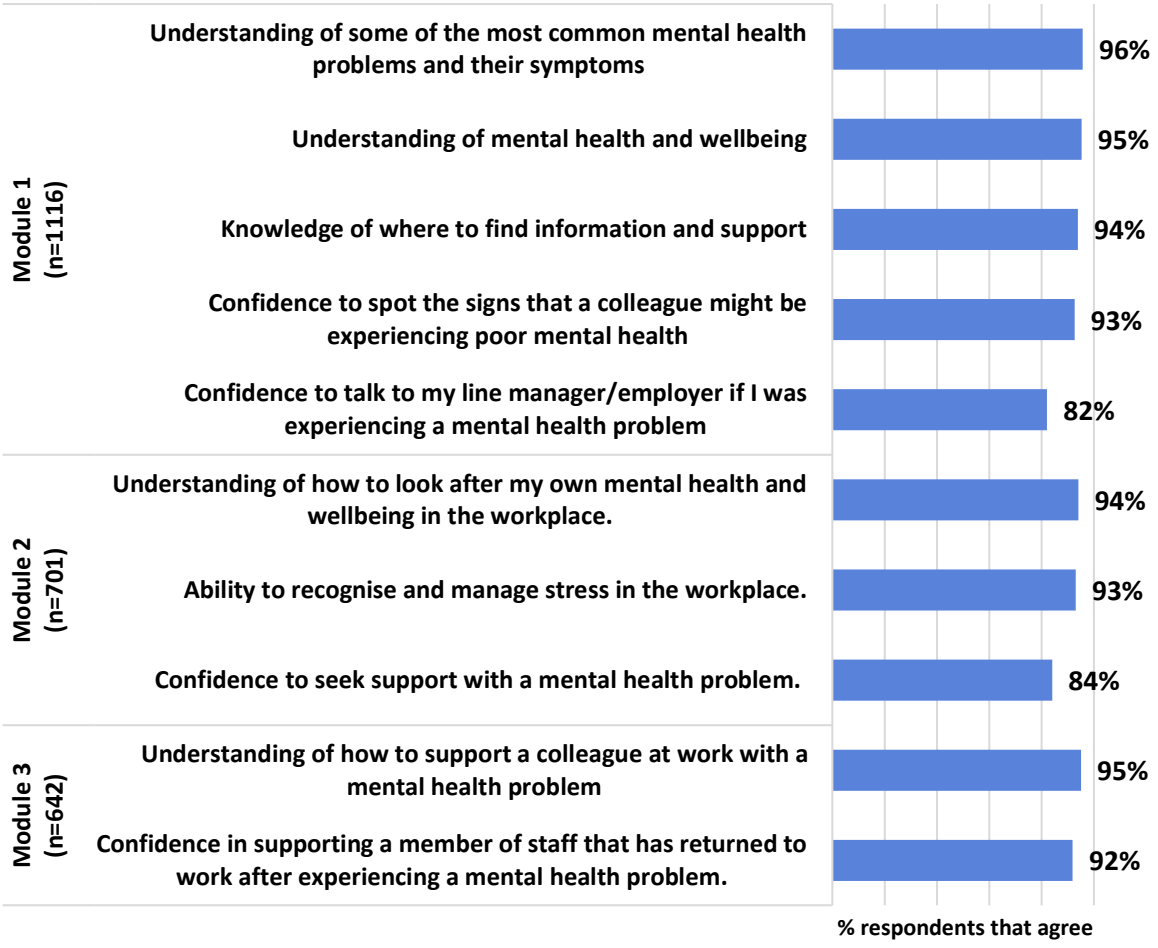
This section explores the differences we were able to evidence in terms of learning and behavioural change – levels 2 and 3 of the Kirkpatrick model.

6.1 Increasing knowledge and confidence

Immediately after completion of modules, users were asked to self-assess changes in their knowledge and confidence. Figure 12 shows that the training was highly effective in increasing knowledge and confidence across a range of measures.

Figure 12 – Almost all survey participants responded positively to the outcome statements immediately after completing each module

"The module has increased my…"



Interviews supported this, with the vast majority of interviewees reporting enhancements to their knowledge, understanding and confidence about their own and others' mental health. The most commonly reported aspects were:

- how they could better look after their own wellbeing
- supporting and discussing mental health and wellbeing with colleagues

> "It was thought provoking. The thing I got most out of it was asking questions if you see something not right, like someone you can see is uncomfortable"

When comparing the findings against the outcome statements detailed in the figure above, there was very little difference between those with a lived experience of mental health problems and those without across the majority of statements. However, there were three where there was a more notable difference. 6% more people with a lived experience reported that they were better able to recognise and manage stress in the workplace than those without. In terms of confidence to seek support about a mental health problem and confidence to talk to their line manager/employer about a mental health problem, fewer people with a lived experience reported an improvement (9% and 10% respectively) than those without.

When looking at results on the basis of organisation size, there was some variation across the different statements (higher and lower) but nothing notable. Furthermore, the sample sizes were too small to draw any robust or meaningful conclusions. This is the same when comparing sectors.

6.2 Acting as a catalyst for action

In addition to self-assessed learning impacts, respondents indicated they intended to apply their learning in some way, including:

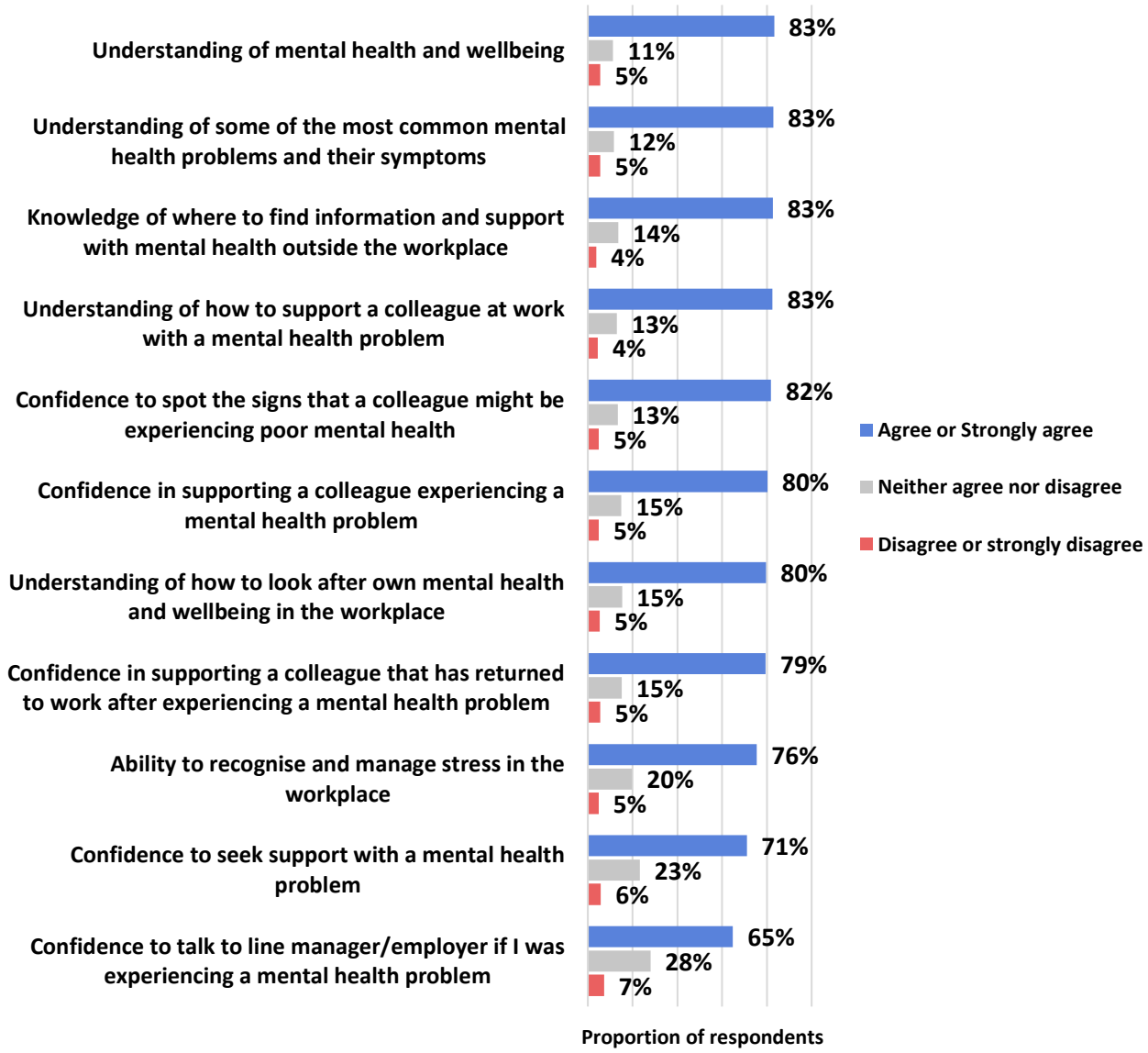
- 85% would consider using The Five Ways to Wellbeing
- 77% had tried, or planned to try, mindfulness/relaxation techniques
- 62% had visited suggested resources/links to external web sites
- 88% indicated they would take action such as:
  - Create times and places to have conversations
  - Support/approach/speak with colleagues
  - Put up posters to raise awareness
  - Put kindness boxes/notes in place
  - Additional training/research
  - Strategies & policies
- 67% had visited suggested resources/links to external websites

Again, the feedback received during interviews supported the survey findings. For some, the changes resulted in being better equipped to recognise their own triggers and situations that affected their mental wellbeing. Others felt it had introduced them to things to help them better look after themselves. This included practicing mindfulness, making sure they were taking regular breaks and/or getting outside during the working day. Others reported that the training had been a trigger to open up discussion with colleagues and introduce time and space through the week to bring people together and check in on each other.

6.3 Durability of learning

Whilst a positive response immediately after training is encouraging, the extent to which it is retained and utilised is key. The follow-up survey allowed respondents to again self-assess the difference the training had made to their knowledge, understanding and confidence, to give a measure of the longer-term retention of what was immediately gained from the training. Again, results were high, demonstrating the durability of the learning.

Figure 1 – The training achieved its intended outcomes within most respondents also in the longer term (based on follow-up survey)

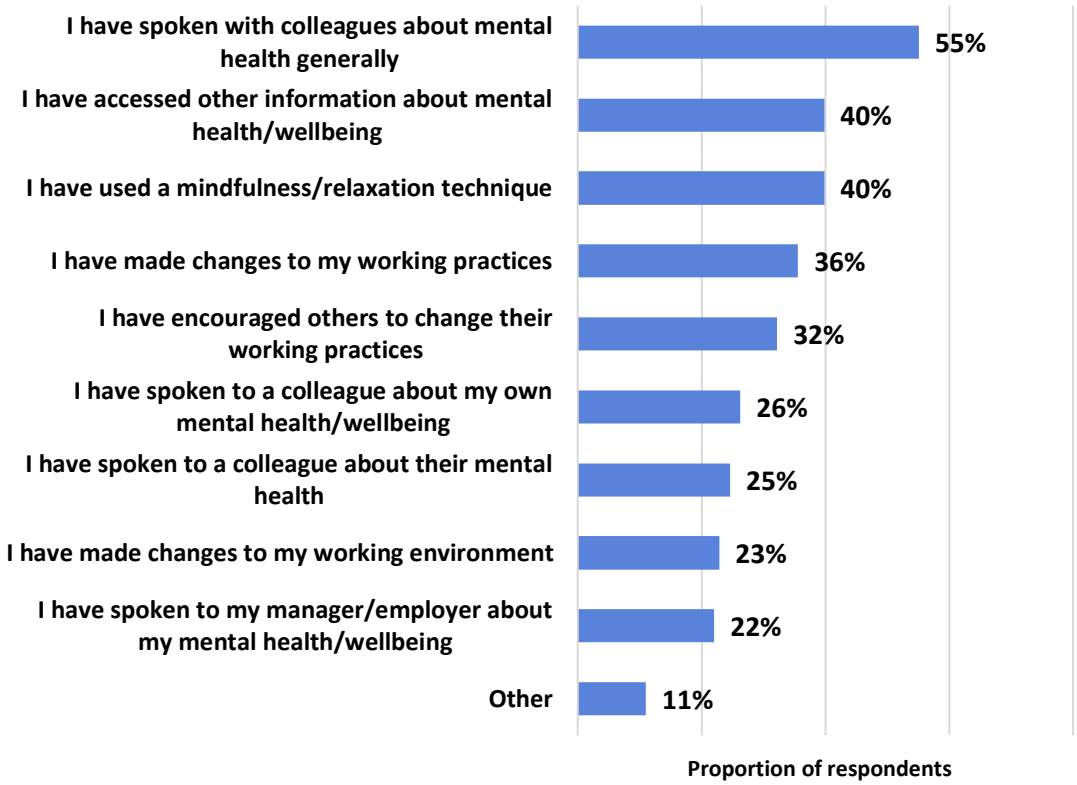


The two outcomes which scored lowest, both immediately after completion and during follow-up, related to individuals seeking support in the workplace. Lowest of all being confidence to speak to a line manager/employer. This is perhaps unsurprising, given that there is still some stigma attached to mental health problems, and individuals may still be concerned about perceived impact on their employment should they divulge a mental health issue. Interviewees sometimes said that, rather than share with a line manager, they would prefer to be able to speak to a mental health champion or another approachable colleague. However, the results are still very positive overall. Furthermore, it is possible that some of those that responded with disagree or neither agree/disagree, already felt confident about seeking support or speaking to their line manager/employer. Certainly during interviews, some users reported that they were part of very supportive workplaces where staff mental health and wellbeing was prioritised.

6.4 Encouraging individuals to look after themselves and others

At follow-up, over a third of respondents reported already doing something different to help their own or their colleagues' mental wellbeing at work, having conversations about mental health ranking highest. This was supported by our interviews, where opening up conversation was reported as being a small but important step forward.

Figure 14 – What respondents are doing differently as a result of the training



N=118

NB The other category included encouraging and promoting engagement with mental health topics generally and the training specifically. Also, simple things such as booking time for themselves.

More specific and personal conversations were also taking place, with a quarter of respondents saying they had spoken about their own mental health with a colleague. Some interviewees also revealed that they had felt able to speak to a colleague they thought was having problems, or had shared their own history with mental health problems. Interviewees were also taking practical steps to improve their working practices, such as taking more frequent breaks, getting away from the desk and practicing relaxation exercises.

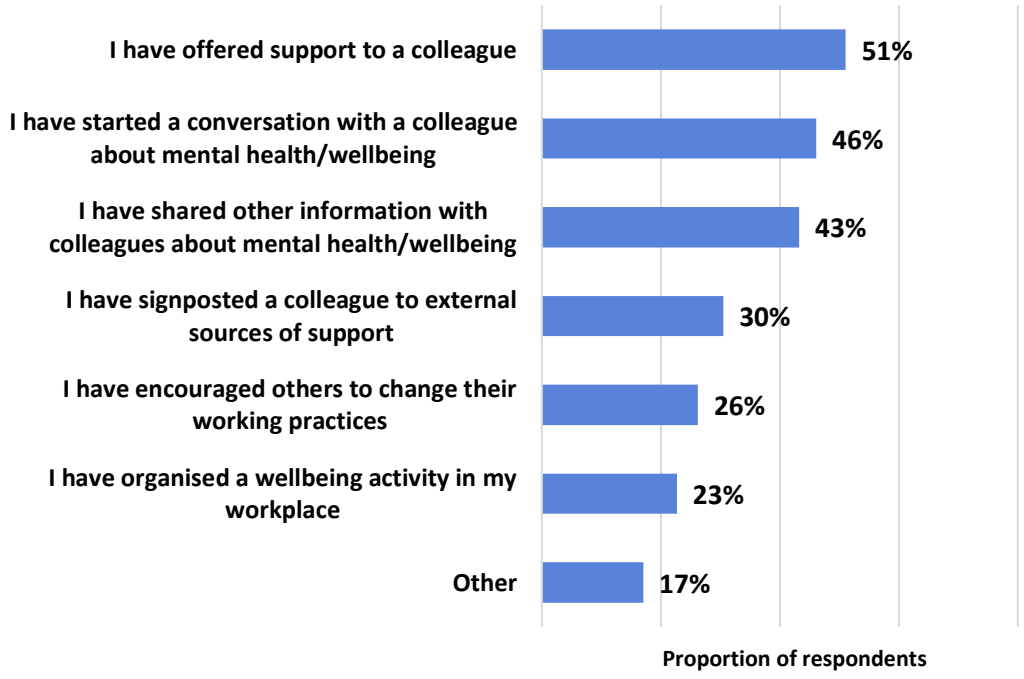
> "I think it opened a conversation, where people that work with mental health were able to discuss their own mental health with other staff. That was the most important thing for me"

44% of respondents that had not taken action to improve their own mental wellbeing reported that it was because they didn't feel they needed to. Several interviewees reported that they were already very proactive about managing their wellbeing and had good practices in place. However, a third of survey respondents felt they didn't have time to make changes to improve their mental wellbeing.

6.5 Facilitating proactive support

As well as making changes to look after their own mental health and wellbeing, respondents also reported being more proactive about supporting colleagues as a result of the training. 47% of respondents reported they had done something to support their colleagues' mental wellbeing at work, with the types of action shown in the figure below.

Figure 15 – Offering support, starting a conversation and sharing information with colleagues are the most common changes that people have made to support others

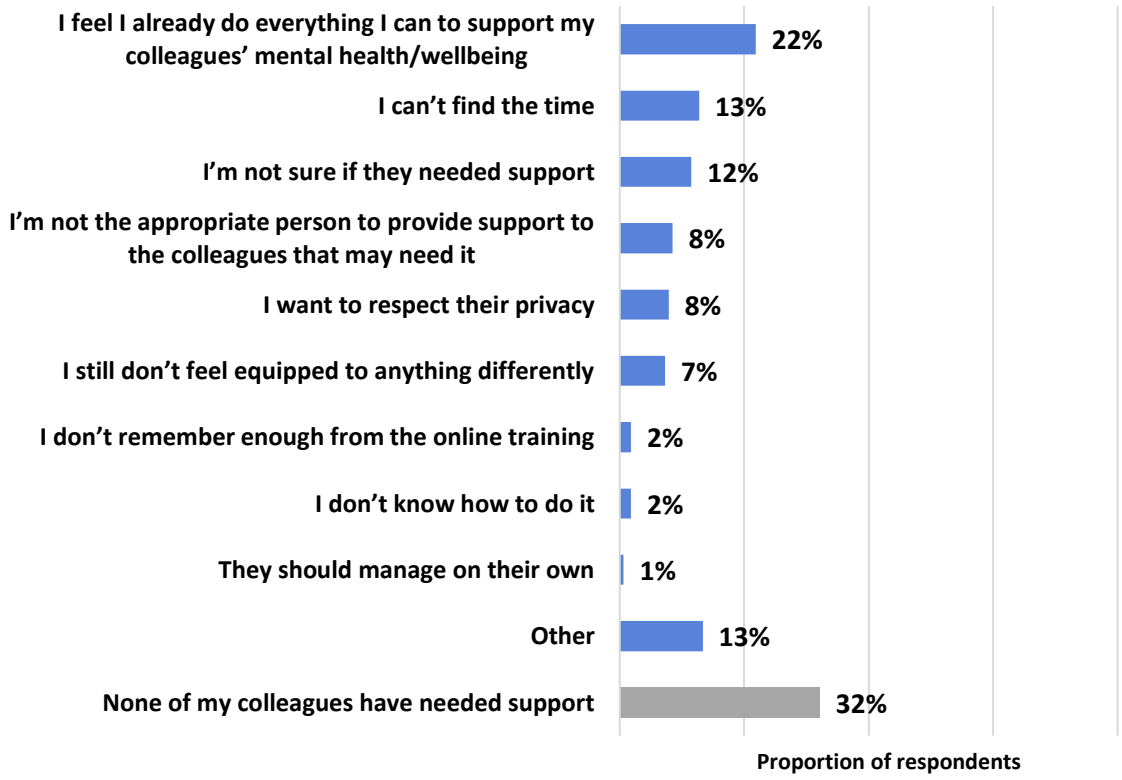


N=141
Other included promoting this or other mental health training.

A further 30% of respondents were planning to do something in future.

Of those that said they had not made any changes, 22% felt they were already doing enough to support their colleagues and 32% felt none of their colleagues need support. This is hopefully a positive indication of healthy and supportive workplaces, which was the main reason for having not made changes, though could indicate some with mental health problems still go unnoticed or unsupported. Whilst lack of time was identified as a barrier for taking action there also remains a level of uncertainty for some about being able to approach someone and being sure a colleague needs help. There is also a sense from some that they still don't feel properly equipped or are perhaps not the most appropriate person to provide support.

Figure 16 – Lack of time again featured as a barrier for making change and also uncertainty about providing support



6.6 Organisational and cultural change

The evaluation period was too short to see real change at organisational level. However there are indicators that changes made as a result of the training will have a positive impact on both organisational processes, and more importantly, cultures. It is important to note, however, that through our interviews it was apparent that not all organisations are perceived to need cultural change, as they are seen by staff as supportive and giving the appropriate prominence to staff mental health and wellbeing.

> “I feel like I'm quite good at supporting them already, so it hasn't made me do it more, just reassured me that I was doing some of the right things.”

That said, we have already described the changes individuals are making. As the training spreads within an organisation, where change is needed this should help to prompt and enable it. The impact of opening conversations is perceived to help reduce stigma and help get the message across that it is OK to speak up. Furthermore, the knowledge and confidence developed will help colleagues provide support to each other, which could potentially have a substantial impact.

One organisation described how the training worked at both organisational and individual level:

> “[It has] Raised awareness within our workplace and has helped us start a conversation about mental health. Also challenged the stigma. Helped me as a manager to have discussions with employees about this and help them appropriately.”

From a practical perspective, we heard of measures being taken to raise awareness and educate the workforce through this and additional training. A few interviewees also reported that it was a gateway to more formal in-depth college-based training relating to mental health in the workplace. Other examples included the appointment of mental health champions in the workplace.

We heard of initiatives such as wellbeing events and get-togethers being put in place to give people time to talk, share and support each other. For example:

> “I am holding a tea, biscuit and a chat morning to talk about wellbeing in our workplace. I will be holding Wellbeing Wednesday's where staff will lunch together away from the office and not talk about work.”

Some managers also used their training to inform the development of wellbeing strategies and policies. One described the steps they were taking to make a wide range of organisational changes:

> “Discussions are now taking place about providing mental health first aid training for some individuals. I shall also be programming some relevant mental health training for line managers and some general mental health training for other staff. As an organisation we have also agreed to sign up for the Mindful Employer Charter. This will involve me reviewing our recruitment documentation and workplace HR policies and procedures.”

Encouragingly, 81% of respondents with line management responsibilities stated feeling better equipped to support an employee returning to work after experiencing a mental health problem as a result of the training.

7 CONCLUSIONS AND RECOMMENDATIONS

7.1 Summary and conclusions

7.1.1 Reach

The training reached all sectors, with notably higher uptake in third sector organisations and education. Micro organisations and nations outside England were underrepresented. Around half the users were line mangers, leaders or HR professionals.

Users tended to already be looking for training or information about mental health in the workplace. Some of this was driven by personal interest, with a high proportion of users having lived experience. Organisation responsibility and duty of care was also a reason for taking up the training, with managers, leaders and HR professionals recognising the need to ensure mental wellbeing in the workplace was being addressed and given the priority it required.

The training was therefore not an initiator of organisational change, as organisations already recognised the need to do more in this sphere, and were looking to the training for guidance on how to do so. However, it provided a good jumping off point for making the desired organisational changes, or as a tool to support and enable progress. Moreover, the findings suggest that the training can act as a catalyst for individual change, whether that was in terms of staff looking after their own mental health or that of their colleagues.

What is less clear is how effective the training would be for organisations not already at the point of wanting to make change. It is likely that in itself the training would not be enough to push an organisation into a decision to make change. Careful consideration would need to be given to reaching out to the less engaged without some other planned activity to initiate behavioural change. However the implications of trying to do this at scale should not be underestimated.

We detected through the evaluation that the changes in public discourse, including the work being done by Heads Together, was already helping organisations become more aware and reach the decision that change was needed. It may therefore not be necessary to add to that work directly as part of this initiative but follow behind the tide of change created by other campaigns and initiatives.

7.1.2 Effectiveness and outcomes

The training itself was accessible, user friendly and engaging. It delivered well on its learning outcomes, leading to increased knowledge, understanding and confidence.

7.1.3 Learning leading to action

Conversations about mental health have been started, and employees described feeling better able to look after themselves and support colleagues. Though each of the changes made is quite small, they are happening at scale and so have the potential to lead to increased awareness, reduced stigma and a more supportive environment for people in the workplace.

Importantly, many of the small changes were behavioural and attitudinal, which we would suggest are sustainable and lasting. Process and systems changes do not usually lead to cultural and lasting changes unless supported by individuals thinking and behaving differently.

Our findings indicate that to maximise the impact and reach of the training requires employer support. It therefore makes sense to target employers, leaders and managers, and help them make best use of the training organisationally.

7.1.4 Potential impact on people with mental health problems

Given what we have seen and heard, and the relatively early stage in the training’s time in the market, it is reasonable to conclude that the positive changes taking place in workplaces as a result of training will have a positive impact on the experience of people with mental health problems in the workplace in the longer term.

7.2 Recommendations

We have a small number of recommendations:

7.2.1 Refine the training package

The training package has been well designed, therefore little needs to be done other than keeping it up to date. If the ’glitch’ which seems to prevent some people from getting their certificates when they have apparently completed the training can be resolved, that would remove some frustrations. Additional narration would increase accessibility, though there is a cost implication.

7.2.2 Promote it more

The peak during Mental Health Awareness Week would indicate that promoting mental health generally, and the training specifically, with employers could accelerate take up. Targeted promotions that focus on organisations/locations that are currently underrepresented may also be useful.

7.2.3 Provide tools for employers to support roll out

Consider a package of information and tools that will help employers and line managers to roll out the training more proactively, and encourage them to give staff protected learning time. A dashboard function would enable an employer to monitor completion.