Monitor
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Mental health and employers: The case for investment

Supporting study for the Independent Review

October 2017

Contents

Introduction and Executive summary

Theresa May announced a series of mental health reforms in the UK on 9th January 2017. As part of this, an Independent Review of Mental Health and Employers was commissioned to understand how employers can better support all individuals currently in employment (including those with poor mental health or wellbeing,) to remain in, and thrive through work. This report aims to support the *Stevenson-Farmer Review of Mental Health and Employers* and offer detailed insight into the cost to employers of failing to address and support mental wellbeing in the workplace.

We aim to answer three specific, supporting questions through this report:

1. What is the cost of mental health to employers?
2. What is the return on investment to employers from mental health interventions in the workplace?
3. What can we learn from international examples in terms of good practice?

As with physical health, mental health varies by individual and can fluctuate over time. Poor mental health and wellbeing can impact an individual's ability to thrive at work and earn a living. While mental health problems in the workplace are not necessarily caused by work, employers should be encouraged to identify and support individuals who bring their mental health problems to work with them, as well as provide mentally healthy working conditions.

In response to this, employers can offer a range of activities to support individuals' personal circumstances, enabling them to take the best course of action for their mental health. Offering these activities is not only beneficial for employees and society, but can reduce the significant employer costs of absence, presenteeism and employee turnover. These supporting activities include awareness-raising and promoting a positive and open organisational culture around mental health, preventative activities to support individuals to cope in difficult circumstances, and reactive support. Our research shows that whilst many employers offer reactive support, providing support at earlier, preventative stages of the employee journey may deliver a better average return on investment.

We estimate that poor mental health costs UK employers £33bn–£42bn each year. This is made up of absence costs of c. £8bn, presenteeism costs ranging from c. £17bn – £26bn and turnover costs of c. £8bn. We also estimate c. £1bn in costs related to self-employed absence. This cost is disproportionately borne by the public sector, which makes up roughly a fifth of the UK labour force, but bears one quarter of total costs. This is driven by higher average per-employee mental health costs in the public sector. Across industries the highest per-employee annual costs of mental health are in the finance, insurance and real estate industry (£2,017–£2,564) and public sector health (£1,794 – £2,174).

In order to calculate the costs of poor employee mental health, we considered a range of costs from absence, presenteeism, team costs and turnover/other organisational costs. Based on overall cost impact, data availability and robustness, we have included absence, presence and turnover costs for employees, and absence costs for the self-employed. We then calculated costs by sector (public vs. private) and by the industries/services within this.

There are a number of trends and data sources supporting our findings in these areas:

- Over the last decade, workplace absence has fallen. However, the proportion of days lost due to poor mental health has risen. This may be partly due to improved reporting linked with increased awareness. Nonetheless, diagnostic evidence shows an increasing prevalence in mental health conditions across the UK population. Levels of mental health-related absence also varies across sectors.
- Presenteeism is defined as attending work whilst ill (in this case, with poor mental health), and working at reduced productivity. We estimate that mental health-related presenteeism costs employers up to three times the cost of mental health-related absence. Costs of presenteeism have increased at a faster rate than absence costs. Presenteeism and absence are very closely linked, as individuals may choose to absent or present in response to poor mental health. The faster growth in presenteeism is partly due to changes in the working environment such as an increase in perceived job insecurity and an increase in remote working, which can encourage more employees to present rather than absent in response to poor mental health. Finally, presenteeism varies significantly by sector, with the highest proportion of present days within natural resources and chemicals, pharmaceuticals and life sciences.
- Recent data shows that as more people choose to leave their employer voluntarily and spend less time, on average, at each employer, mental health related turnover costs increase. Studies suggest that higher paid and higher skilled jobs will incur greater turnover costs due to increased exit costs in finding the right candidate and increased entry costs of lost output, as the new employee gets up to speed.
- Self-employment is rising in the UK, and our analysis conservatively estimates mental health-related absence costs. Our research suggests that the self-employed are less likely to absent than those who are employed. The impact of mental ill health on these absence rates is less clear given limited data. Our estimates of self-employment mental health costs are likely to be conservative as we have not included presenteeism or turnover costs for the self-employed workforce.

The return on investment of workplace mental health interventions is overwhelmingly positive. Based on a systematic review of the available literature, ROIs range from 0.4:1 to 9:1, with an average ROI of 4.2:1. These ranges account for a number of data sources and methodologies. Our research indicates that these figures are likely to be conservative given the declining cost of technology-based interventions over time, increase in wages, cross-country differences and limited consideration of the full breadth of benefits. There are opportunities for employers to achieve better returns on investment by providing more interventions at organisational culture and proactive stages enabling employees to thrive, rather than intervening at very late stages.

There are a number of lessons we can draw from other countries in relation to employers and mental health and wellbeing. Looking across Germany, Canada, Australia, France, Belgium and Sweden reveals a range of interventions and approaches in this space. Examples of good practice in Germany, Canada and Australia suggest that providing a common framework around mental health interventions and engaging with key stakeholders can empower employers to implement the most helpful interventions for their workforce. On the other hand, France, Belgium and Sweden have focused on legislation to protect employee mental health and wellbeing.

We hope that you find the research insights informative, thought-provoking and of practical help for employers seeking to play a greater role in supporting the mental health and wellbeing of their employees. As always we welcome your feedback and comments.

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Definitions

Mental Health[1]
Mental Health is defined by the WHO as a state of mental and psychological wellbeing in which every individual realises his or her own potential, and can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. Mental Health is determined by a range of socioeconomic, biological and environmental factors.

Wellbeing[2]
Wellbeing is defined by the UK Department of Health as feeling good and functioning well, and comprises each individual's experience of their life and a comparison of life circumstances with social norms and values. Wellbeing can be both subjective and objective.

Mental wellbeing[3]
Mental wellbeing as defined by Mind, describes your mental state. Mental wellbeing is dynamic. An individual can be of relatively good mental wellbeing, despite the presence of a mental illness. If you have good mental wellbeing you are able to:

- Feel relatively confident in yourself and have positive self-esteem
- Feel and express a range of emotions
- Build and maintain good relationships with others
- Feel engaged with the world around you
- Live and work productively
- Cope with the stresses of daily life, including work-related stress
- Adapt and manage in times of change and uncertainty

Work-related stress[4]
Work-related stress, as defined by the WHO, is the response people may have when presented with demand and pressures that are not matched to their abilities leading to an inability to cope, especially when employees feel they have little support from supervisors as well as little control over work processes.

Presenteeism[5]
Presenteeism is defined as attending work whilst ill and therefore not performing at full ability. Presenteeism can be both positive and negative and be due to a variety of factors. In this report we will use presenteeism to mean 'mental health related presenteeism'.

Absence
In this report we define absence as days absent from work. Absence can also be both positive and negative and due to a number of factors. In this report we use absence to mean 'mental health related absence.'

Turnover
In this report, we define turnover as employees leaving and being replaced in a workforce. In this report we use turnover to mean 'mental health related turnover.'

Mental Health in the Workplace: An employee journey

As with physical health, mental health varies by individual and can fluctuate over time. Poor mental health and wellbeing can impact an individual's ability to thrive at work and earn a living. In response to this, employers can offer a range of activities to support individuals' personal circumstances, enabling them to take the best course of action for their mental health. Offering these activities is not only beneficial for employees and society, but can reduce the significant employer costs of absence, presenteeism and turnover. These supporting activities include awareness-raising and promoting a positive and open organisational culture around mental health, preventative activities to support individuals to cope in difficult circumstances, and reactive support. Our research shows that whilst many employers offer reactive support, providing support at earlier, preventative stages of the employee journey may deliver a better average return on investment.

1 An average employee's mental health fluctuates between thriving and struggling but they are largely able to work effectively and productively

2 Employers aware of the importance of supporting mental health and emotional wellbeing, have an organisational culture of openness, acceptance and awareness. This can include mental health de-stigmatisation campaigns, mandatory training on wellbeing and activities to support employee resilience. As a result, more individuals will understand the link between their mental health and productivity, and what to do when they or their colleagues experience challenging circumstances. **Research shows that the ROI of these early-stage supporting activities can range up to 8:1**

3 An employee experiences an event, or series of events, which could be caused by personal, health or work factors. This causes the individual's mental health to worsen and they may need some form of support. At this stage, they may or may not seek support from friends, family, professionals or their employer.

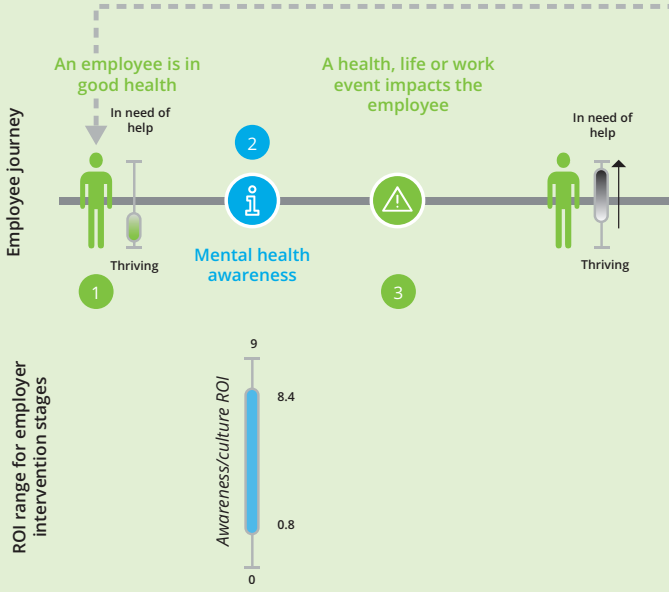
4 An employer may offer support for individuals experiencing periods of poor mental health. It could target this support through diagnostic/screening tools, or provide training for employees to spot and act on signs of poor mental health in themselves and others. This support could take the form of training, use of employee assistance programmes or discussions around workload and working styles. These interventions are designed to support the employee to improve their mental health and, if possible, to recover and thrive again. If the individual cannot find support within or outside the workplace, their mental health may worsen. **Research shows that the ROI of these proactive interventions can range up to 6:1**

5 An employee is struggling, and makes a choice about their relationship with work. They may choose to absent (take time off) or present (continue to work, but at a reduced capacity due to illness and may not be physically present). This decision can impact the individual's mental health in a positive or negative way depending on work-related and personal characteristics.

For example, choosing to absent can be positive if absence from work does not put additional pressure on the individual, and they can use this time to rest and recover. However, a series of personal and work-related factors can make the decision to absent either difficult or negative for the individual. These may be linked to poor job security, reduction in income, concerns as to how their absence will be perceived, impact on their team, or a lack of support and companionship outside the workplace. **We have estimated the cost to UK employers of mental health-related absence at £7.9bn.**

Alternatively, choosing to present and come into work may result in reduced productivity. This can be positive for the individual if this contributes to the employee's wellbeing or they receive additional support from the employer. This may not always be possible if job demands or team working arrangements are inflexible, or impact on reward or progression. This can be further exacerbated by workplace culture, stigma or a lack of understanding around mental health. All of these factors can prevent employees from speaking up about their circumstances or conditions. As a result, individuals may continue to experience the same workplace demands but with a reduced capacity to cope. This could have negative impacts on their mental health. **We have estimated the cost to UK employers of mental-health related presenteeism at between £16.8- £26.4bn**

Mental health in the workplace: An employer journey[a]



Note: a – To see a full page version of this diagram please refer to Appendix 1

6 If an individual's condition becomes more severe, the employer may offer reactive interventions. These include therapy and access to mental health professionals e.g. through occupational health. **Research shows the ROI of reactive interventions can range up to 5:1**

7 The inter-relation between an employee's mental health and their work may cause an employee or employer to consider whether or not they can continue at the organisation. Again, the impact of these circumstances on the individual is due to a range of personal and workplace characteristics.

8 The employee may choose to stay at their current employer and thrive if they have the right, supportive conditions at work or personal circumstances change. However, they may choose to stay at the risk of worsening their mental health. Reasons for this include concerns about their ability to find another job, lack of financial security, poor understanding of their condition or other external pressures to stay in their role.

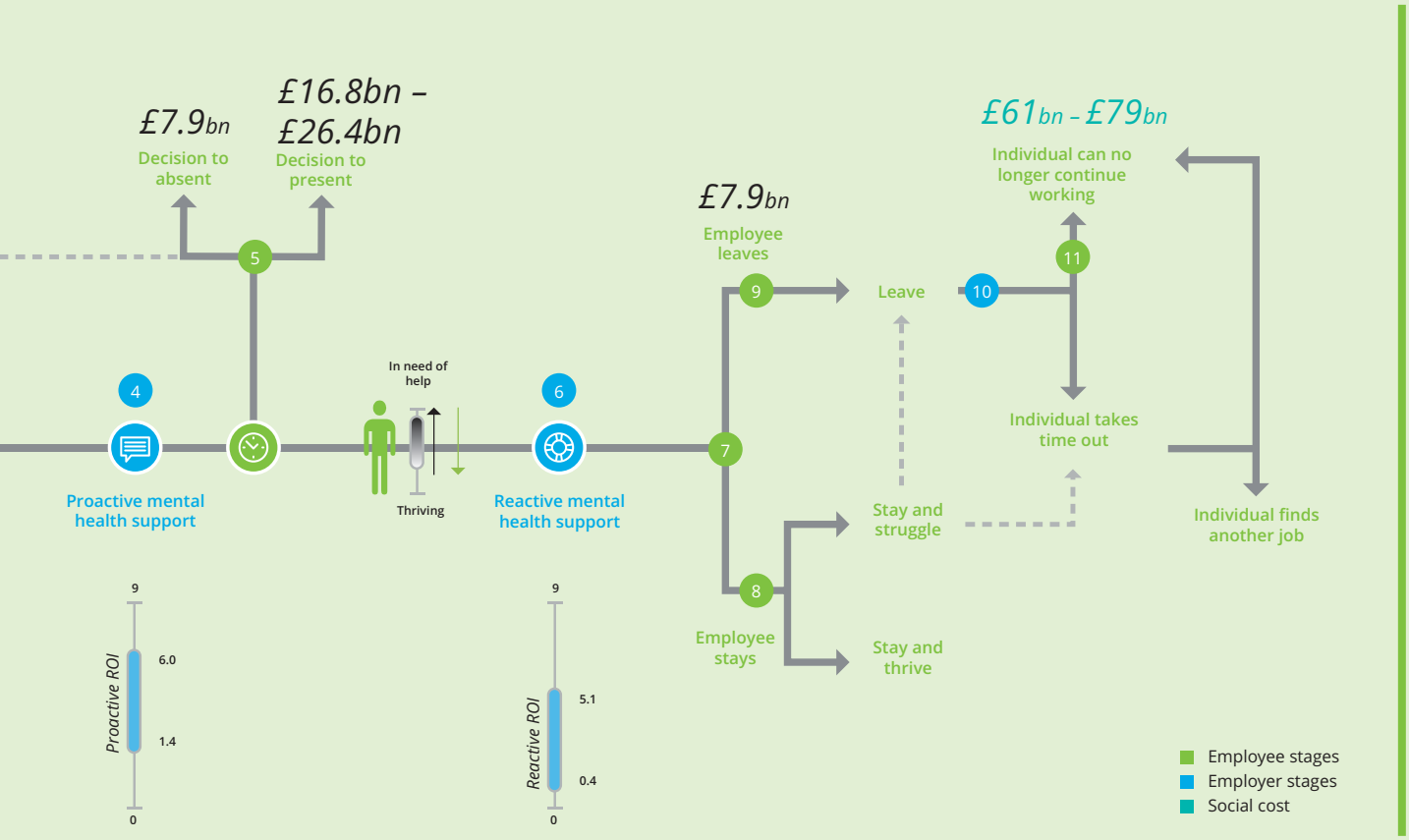
9 Alternatively, the employee may leave their employer. This can be positive if individuals use their time out of work to recover or learn new coping mechanisms. Employees may also change their role or employer in order to improve their working conditions. However, their mental health may be negatively impacted by reduced financial security, access to a community and wellbeing support.

10 If an employee leaves the organisation, there will be costs to the employer including those of finding a new employee. These include:

- costs of temporary staff
- agency and job advertisement fees
- time taken to find a new employee
- time and training required before a new hire is able to work at full productivity.

We have estimated the cost to UK employers of mental-health related turnover at £7.9bn

11 Some individuals may be unable to find work after leaving their employer. This can be due to their health or personal circumstances, or experiencing stigma when approaching new employers. This can be exacerbated by long periods out of the workforce resulting in de-skilling, or the severity of their mental health condition. The social costs of these individuals being unable to return to work is estimated to be between **£61bn-79bn** (as stated in the Independent Review), made up of lost output costs, NHS costs and the cost to the Government in benefits and forgone NI and tax.



What is the cost of mental health to employers?

We estimate that poor mental health costs UK employers £33bn – £42bn each year. This is made up of absence costs of c. £8bn, presenteeism costs ranging from c. £17bn – £26bn and turnover costs of c. £8bn. We also estimate c. £1bn in costs related to self-employed absence. This cost is disproportionately borne by the public sector, which makes up roughly a fifth of the UK labour force, but bears one quarter of total costs. This is driven by higher average per-employee mental health costs in the public sector. Across industries the highest per-employee annual costs of mental health are in the finance, insurance and real estate industry (£2,017–£2,564) and public sector health (£1,794 – £2,174).

Total costs

Using conservative assumptions, we reach a total cost of £33bn-£42bn, broken into £8bn absence costs, £17bn-£26bn presenteeism costs and £8bn turnover. We have also calculated costs of self-employed absenteeism at £0.9bn.

Absence cost: £7.9bn + **Presenteeism cost: £16.8bn–£26.4bn** + **Turnover cost: £7.9bn** **Self employed absence cost: £0.9bn**

Sector and industry breakdown

The public sector has a higher average cost per employee, driven primarily by employees in the health sector. Across the public and private sector, the highest costs are due to presenteeism, driving 47-60% of private sector costs and 65-71% of public sector costs.

Private Sector costs: **£24.2bn–£32.0bn**

Figure 1. Private sector breakdown for absenteeism, presenteeism (high and low estimates) and turnover costs

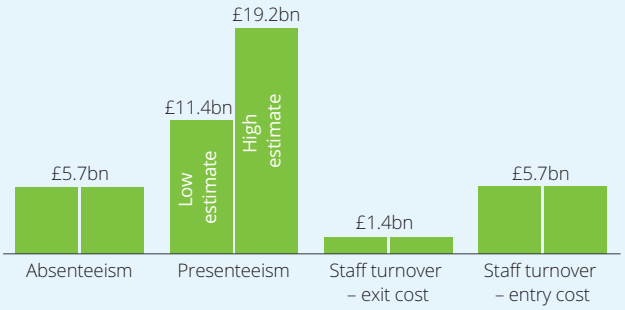
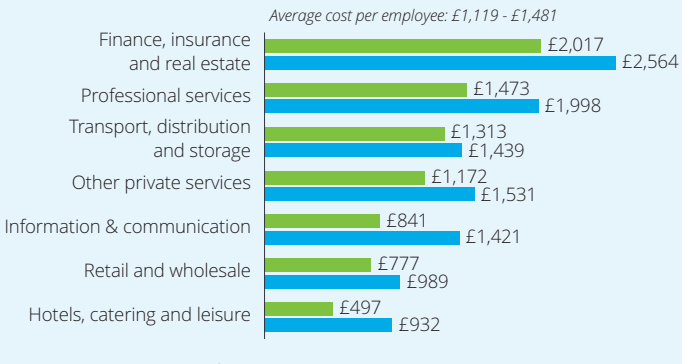


Figure 2. Private Sector poor mental health costs per employee



Public Sector costs: **£8.4bn–£10.2bn**

Figure 3. Public sector breakdown for absenteeism, presenteeism (high and low estimates) and turnover costs

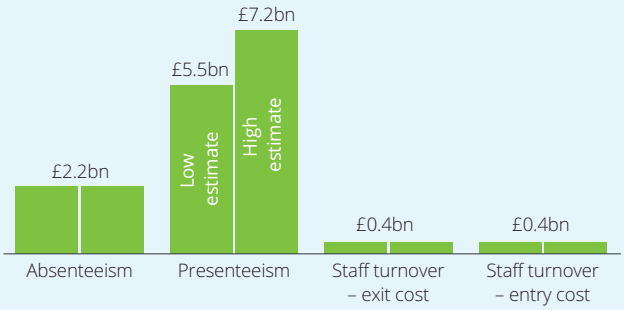
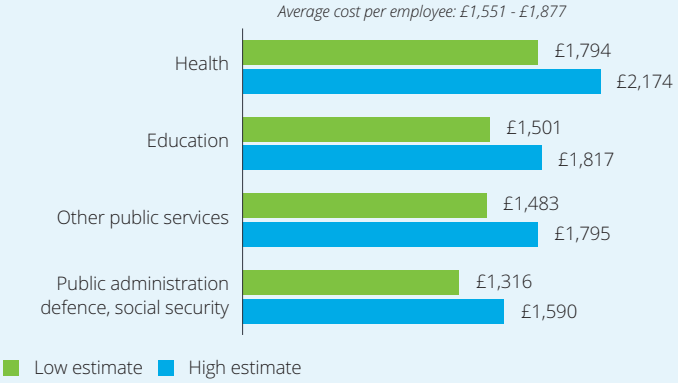


Figure 4. Public Sector poor mental health costs per employee

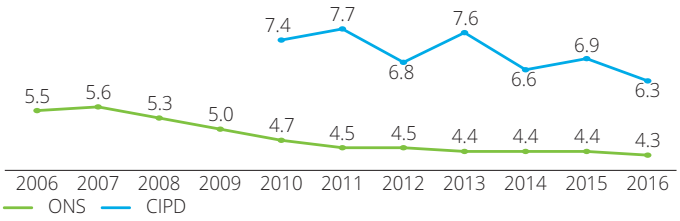


Absence trends

Over the last decade, average workplace absence per employee has fallen. However, the proportion of days lost due to poor mental health has risen. This may be partly due to improved reporting linked with increased awareness. However, diagnostic evidence shows an increasing prevalence in mental health conditions across the UK population. Levels of mental health-related absence also vary across sectors.

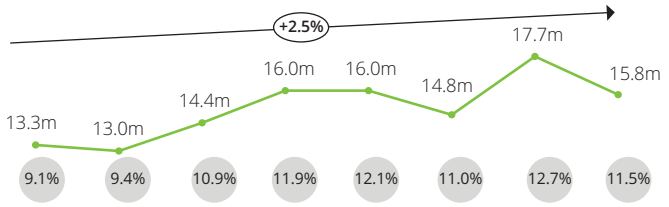
Overall, sickness absence days per worker have been trending downwards in recent years. The top reasons for absence in the 2009 – 2016 period were musculoskeletal problems (25%), minor illnesses (23%), mental health problems (11%), other (15%)[6]. Whilst various data sources DIFFER in their methodology and sources, as seen in figure 5 below, they show the same downward trend.

Figure 5. Average number of days lost due to sickness per worker



Source: CIPD, ONS Labour Force Survey

Figure 6. Reported Av. number of days lost due to mental health related reasons (m, % of total)



Source: ONS Labour Force Survey

Notes: Multiple sources and assumptions used for cost modelling, therefore individual trends may not fully triangulate with final cost numbers

However, total absence due to mental health conditions (stress, depression, anxiety and other serious mental health problems) is rising. This can be seen in data from the ONS Labour Force Survey (see figure 6). As a reported proportion of total days lost due to poor mental health, days lost rose from 9.1% to 11.5% between 2009 and 2016, whilst the total number of days lost has risen by a CAGR of 2.5% over this same period[7]. However this is likely to be an under-estimate of total days lost due to:

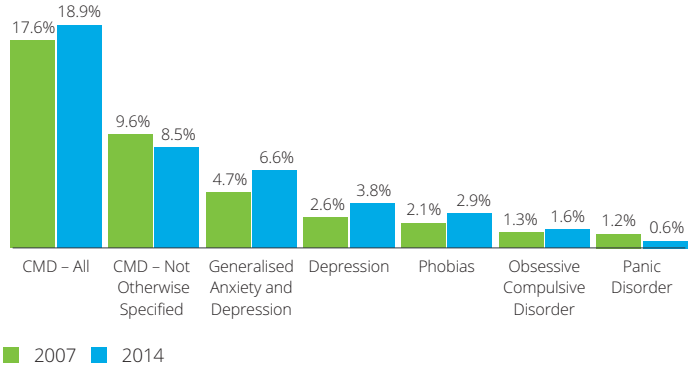
- Employee willingness to disclose their conditions due to stigma (discussed in more detail in the link between absence and presenteeism)
- Lack of understanding around mental health or conditions presenting as physical symptoms such as headaches.

The costs of mental health related absence in the UK workplace is:

£7.9bn

This rise in mental health-related absence is at least partly driven by growing prevalence of common mental health problems. According to the Adult Psychiatric Morbidity Survey, which assesses psychiatric disorder using diagnostic criteria, the overall prevalence of mental health problems has risen between 2007-2014. This is driven by almost all disorders with the exception of panic disorders. For adults over the age of 16, roughly 1 in 6 people met the criteria for a common mental disorder in 2014.[8]

Figure 7. The prevalence of Common Mental Disorders (CMD)



Source: Adult Psychiatric Morbidity Survey

Absence due to mental ill health varies by sector, and may be due to individual characteristics as well as the work environment. In general, sickness absence rates are higher in the public sector at 2.9% vs 1.7% for the private sector. 7.7% of all sickness absence is mental health related.[9] CIPD data shows that public sector has a higher prevalence of reported mental health related problems as well as more stress-related absences.[10] On average, public sector workers lose 3 days per year to mental health related issues vs 1 day per year for private sector.[11] CIPD data also shows that presenteeism is higher in the public sector with 39% of employees reporting observed presenteeism vs 26% in the private sector.[12]

Figure 8. Mental health by sector

Have you seen a change in the number of reported common mental health problems, such as anxiety and depression, among employees in the last 12 months? (%)

Sector	Yes, an increase	Yes, a decrease	No
Private	32	8	60
Public	65	9	26
Non-profit	43	6	51
All respondents	41	8	52

Source: CIPD, Absence management

Note: Multiple sources and assumptions used for cost modelling, therefore individual trends may not fully triangulate with final cost numbers

Presenteeism trends

Presenteeism is defined as attending work whilst ill (in this case, with poor mental health), and working at reduced productivity. We estimate that mental health-related presenteeism costs employers up to three times the cost of mental health-related absence. Costs of presenteeism have also increased at a faster rate than absence costs. Presenteeism and absence are very closely linked, as individuals may choose to absent or present in response to poor mental health. The faster growth in presenteeism is partly due to changes in the working environment such as an increase in perceived job insecurity and an increase in remote working which can encourage more employees to present rather than absent in response to poor mental health. Finally, presenteeism varies significantly by sector, with the highest proportion of present days within natural resources and chemicals, pharmaceuticals and life sciences.

While many individuals with recurring or prolonged mental health conditions are able to work at full capacity, presenteeism is defined as attending work whilst ill[13] (in this case, with poor mental health), and captures the occasions when individuals work at reduced productivity. Figure 9 summarises the ways in which presenteeism manifests itself at work when an employee chooses to present in spite of poor mental health.

The costs of mental health related presenteeism in the UK workplace is:

£16.8bn–£26.4bn

It shows that most employees struggle with concentration, whilst some are more likely to be agitated or confrontational. Almost 10% of respondents said that they would rely on their colleagues to complete work.

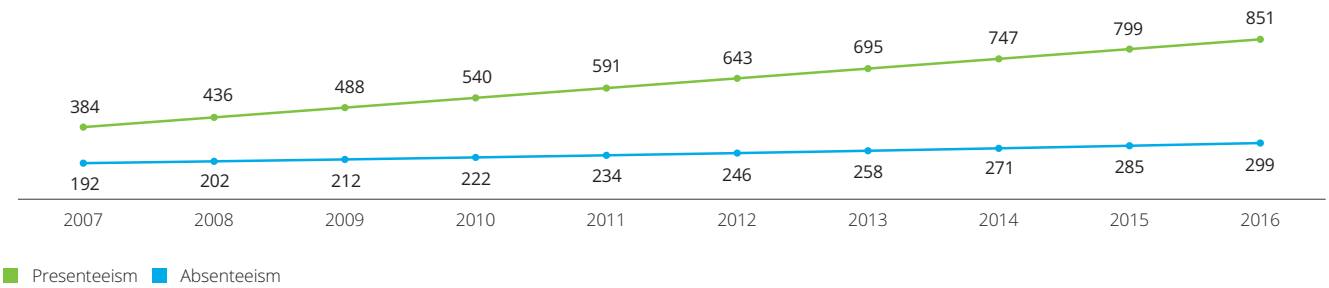
Presenteeism costs can have a substantially greater impact on employers than those related to absenteeism. Based on a series of assumptions derived from research studies and available literature, costs associated with presenteeism tend to cost the employer significantly more than absenteeism, and as shown in figure 10 this gap has been widening in recent years. This is due to a number of factors including:

- An increase in perceived job insecurity:[14]
- Change in working patterns, e.g. remote working

Figure 9. How mental health impacts work % of total respondents who have experienced poor mental health at their current employer (N = 6,567)

Source: Mind Workplace Wellbeing Index

Figure 10. Average cost per year per employee, absenteeism vs presenteeism[a]



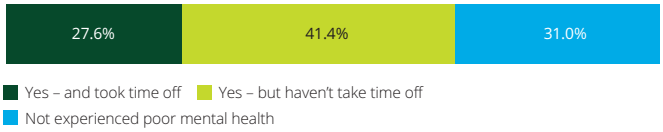
Source: CfMH, ONS, British Heart Foundation

Notes: Multiple sources and assumptions used for cost modelling, therefore individual trends may not fully triangulate with final cost numbers; a – Cost estimates vary from previously released estimates due to differing methodologies

Figure 11 summarises the recent Mind Workplace Wellbeing Index Survey showing how people answered the question, 'Have you experienced poor mental health at your current employer?' Just under 70% of the 9,501 respondents answered 'Yes'.

Of those who had answered 'Yes' to experiencing poor mental health at their current employer, only 40% had taken any time off for their mental health, suggesting that 60% could have chosen to stay in work and present during periods of poor mental health.

Figure 11. Absence due to poor mental wellbeing, % of total respondents (N = 9501)



Source: Mind Workplace Wellbeing Index

The proportion of employees taking time off varies by sector with 31% of private sector employees who have experienced poor mental health at their current employer taking time off compared to just under 50% of public sector employees. We found that the third sector sits between the two with 37% of respondents taking time off for their mental health at their current employer.

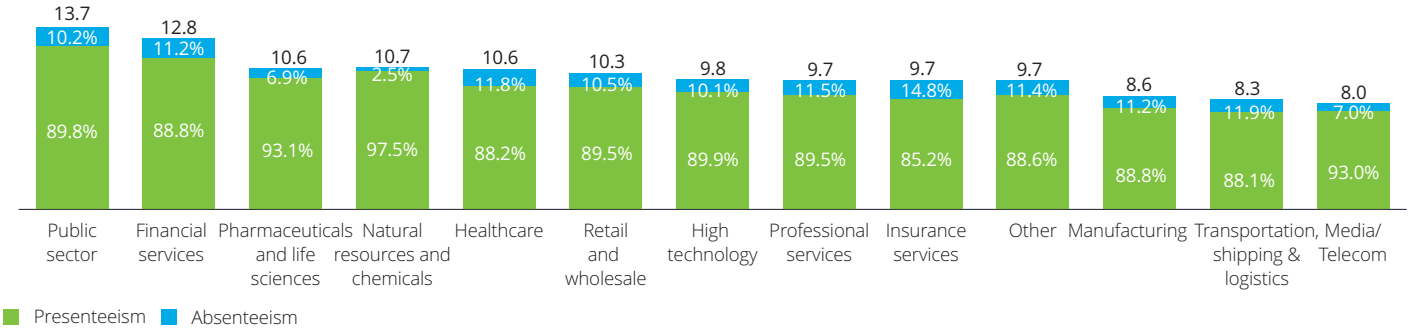
Similarly, when asked if they had ever taken time off work (at any employer) due to poor mental health, 43% of both public and third sector employees answered 'Yes'. On the other hand, a significantly smaller proportion of private sector employees, just under 30%, answered 'Yes'.[15]

However evidence from the "Healthiest Workplace Survey" shows a further breakdown by industry of the differences between absence and presenteeism (as summarised in figure 12) which shows that mental health prevalence varies by sector, which may be driven by stress. Across the industries, presenteeism contributes significantly more to days lost per employee than absenteeism.[16] It is important to note that the total days lost does not equate to total cost as cost varies between absenteeism and presentesim by industry.

The public sector and financial services are where we see people lose the most days, but it is the pharmaceuticals, natural resources and media industries where there is the greatest ratio of presenteeism to absence days.

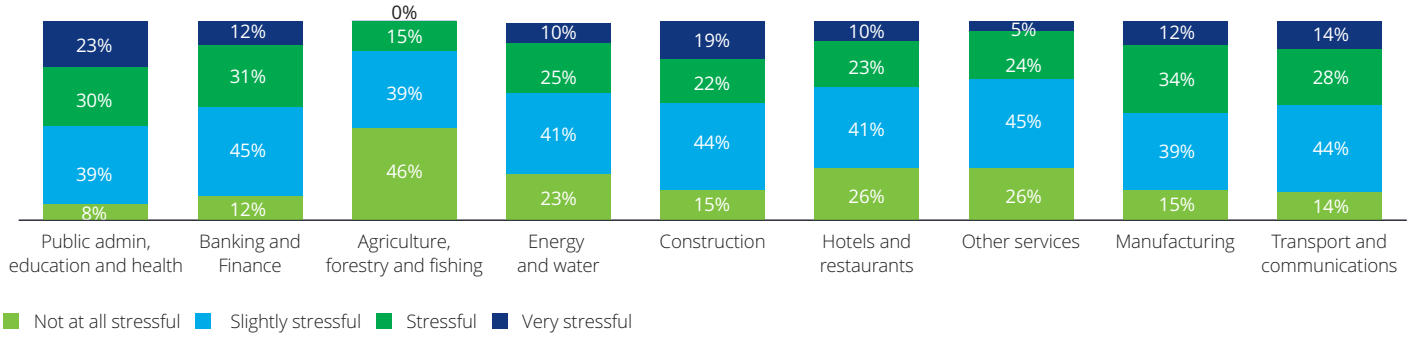
When also considering the levels of stress by industry in figure 13, it can be seen that the industries where the most days are lost – in the public sector and financial services are also some of the industries that experience the greatest levels of stress[17].

Figure 12. Absenteeism and presenteeism impact on days lost per employee



Source: Britain's Healthiest Workplace Survey

Figure 13. Level of stress by industry



Source: ONS Health and Wellbeing at work: A survey of employees

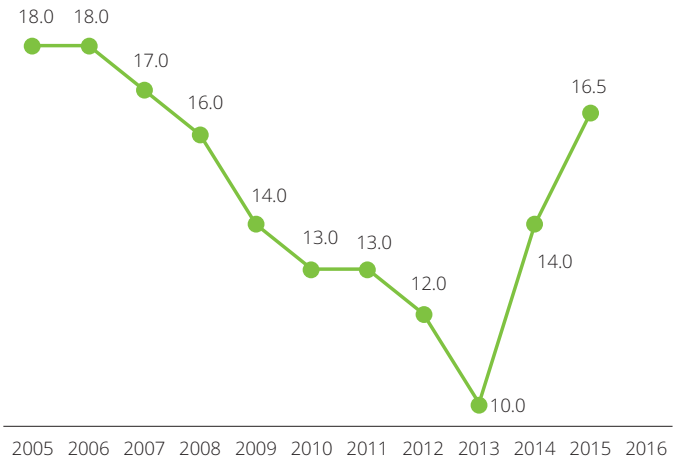
Note: Multiple sources and assumptions used for cost modelling, therefore individual trends may not fully triangulate with final cost numbers

Turnover trends

Recent data shows that as more people choose to leave their employer voluntarily and spend less time, on average, at each employer, mental health related turnover costs increase. Studies suggest that higher paid and higher skilled jobs will incur greater turnover costs due to increased exit costs in finding the right candidate and increased entry costs of lost output as the new employee gets up to speed.

As seen in figure 14, while labour turnover reached a low in 2013, it has once again spiked. When further considering the reasons for leaving, employees leaving voluntarily almost doubled over two years to a median rate of 10% in 2016.

Figure 14. Median rate of labour turnover (%)



Source: CIPD Resource-Talent Planning survey

The costs of mental health related turnover in the UK workplace is:

£7.9bn

Research from Oxford Economics[19] suggest that the costs of turnover can be understood in two ways, which we have labelled entry and exit costs:

- Entry costs cover all the logistical costs associated with having to attract & recruit new talent (e.g. cost of advertising, temporary workers, interviewing and inducting a new employee).
- Exit costs cover all the costs with bringing a new employee up to speed in the organisation and any productivity losses arising from this.

We have found that the cost of turnover is impacted by the following factors:

- The type of sector:
  The greater technical expertise required, the higher turnover costs will be
- The size of the organisation:
  The larger the firm, the higher turnover costs due to increased recruitment and hiring costs and it taking employees longer to get up to speed with company operations
- The type of worker:
  Hiring an individual from the same sector will incur lower costs as they will be largely up to speed and on-board faster; hiring a new worker or someone out of employment will incur higher turnover costs[a]

Studying data on people's reasons for leaving their places of work, particularly the proportion of voluntary resignations due to health reasons or a need for a better work life balance, we have estimated the proportion of turnover that can be attributed to poor mental health to be 7%.

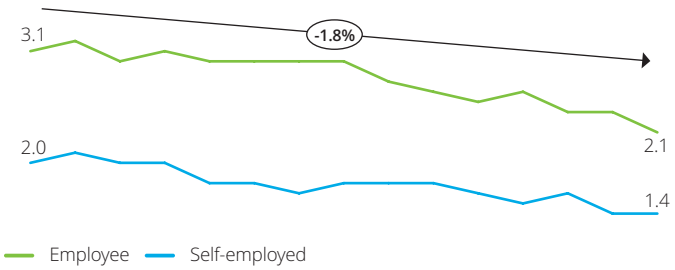
Notes: a – Multiple sources and assumptions used for cost modelling, therefore individual trends may not fully triangulate with final cost numbers; Cost estimates vary from previously released estimates due to differing methodologies and assumptions

Self-employment trends

Self-employment is rising in the UK, and our analysis conservatively estimates mental health-related absence costs. Our research suggests that the self-employed are less likely to absent than those employed. The impact of mental ill health on these absence rates is less clear given limited data. Our estimates of self-employment mental health costs are likely to be conservative as we have not included presenteeism or turnover costs for the self-employed workforce.

Self-employed individuals are less likely to take time off for sickness. This may be due to them typically working fewer hours, not being paid to take days off or choosing to become self employed and therefore having flexibility as to when they work. Using this data, we have calculated costs of self-employment absence due to poor mental health at £0.86bn. This estimate is relatively conservative as it does not take into account the costs associated with presenteeism or turnover.

Figure 15. Sickness absence rates, % of total working hours, 1996-2016[a]



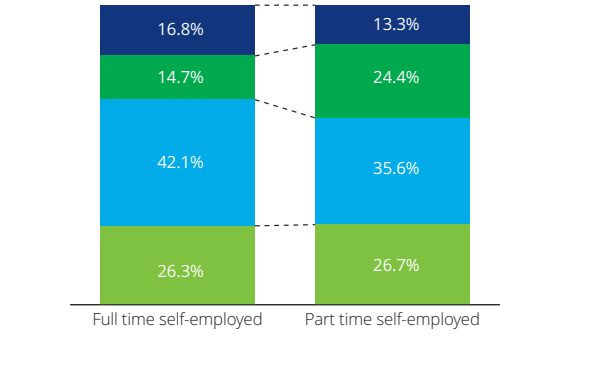
Source: ONS, trends in self employement

The costs of mental health related absenteeism amongst self employed individuals in the UK workplace is:

£860m

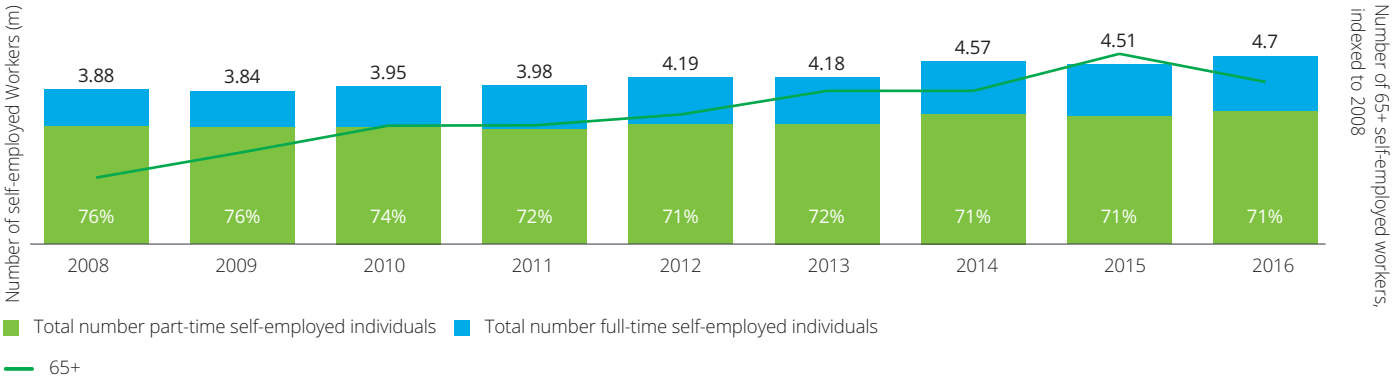
According to ONS data, most individuals choose to become self-employed for positive or lifestyle reasons with fewer choosing to become self-employed due to being unable to find alternative work.[20] Additionally, the number of self-employed individuals in the UK is growing, driven by a growth in part-time workers and over 65s.[21]

Figure 16. Reasons for being self-employed[b], % of total employment, 2015



Source: ONS, Trends in self employment

Figure 17. Self-employment key trends, total self-employed (Actuals) split by part and full time, Number of 65+ self-employed individuals, indexed to 2008 (2008=100)



Source: ONS, Trends in self-employment

Notes: Multiple sources and assumptions used for cost modelling, therefore individual trends may not fully triangulate with final cost numbers

a – 2014/15 prices

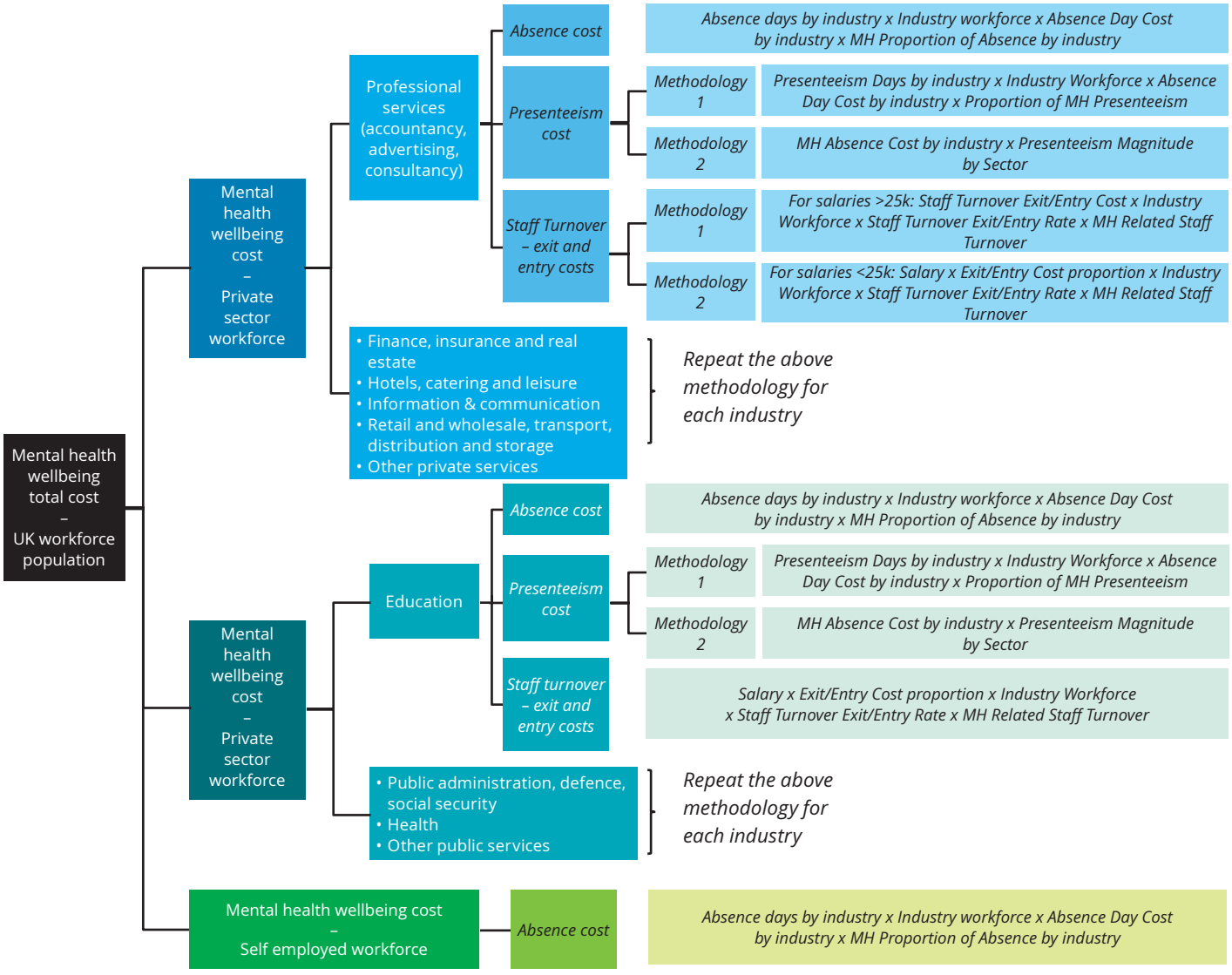
b – Groups defined as follows: 1. Negative: Redundancy, Could not find other employment. 2. Neutral: Other, Started or joined a family business. 3. Lifestyle choice: To maintain or increase income, Job after retirement. 4. Positive: Saw the demand of the market, Nature of job or chosen career, Better work conditions or job satisfaction

Costing Methodology

In order to calculate the costs of poor employee mental health, we considered a range of costs from absence, presenteeism, team costs and turnover/other organisational costs. Based on overall cost impact, data availability and robustness, we have included absence, presence and turnover costs for employees, and absence costs for the self-employed. We then calculated costs by sector (public vs. private) and by the industries/services within this.

Our modelling methodology aims to reach a detailed level of analysis of mental health costs, taking into account the data availability and robustness. Research linked to presenteeism saw the widest possible range of assumptions (outlined in the definitions and assumptions section). This is partly linked to the inherent subjectivity of self-reporting around productivity[22]. As a result, we have used two methodologies for presenteeism. The first relies on reported presenteeism days by industry and the second applies an absenteeism-presenteeism multiplier. Both of these approaches have been used in previous research papers and drive the high and low mental health cost estimates.

Figure 18. Modelling methodology

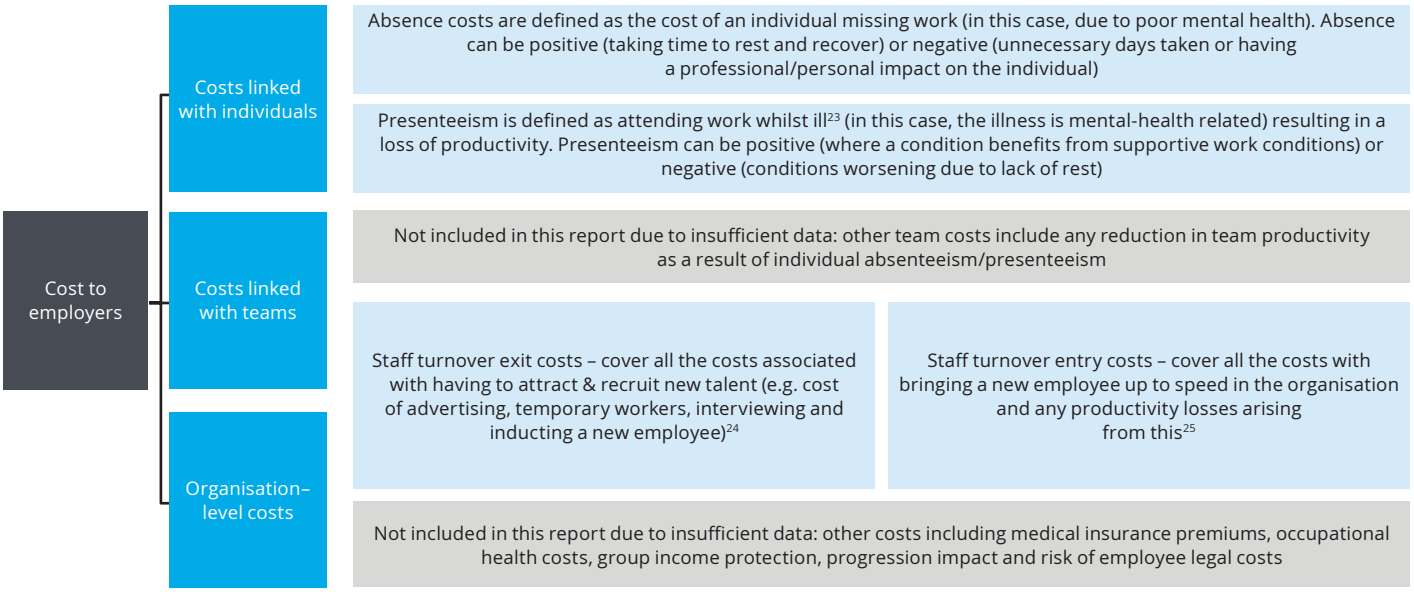


Definitions and assumptions

Definitions

In this report, we consider absence, presenteeism and staff turnover costs. We have used common definitions found in literature and excluded costs which are not sufficiently well-defined or do not have robust data behind them.

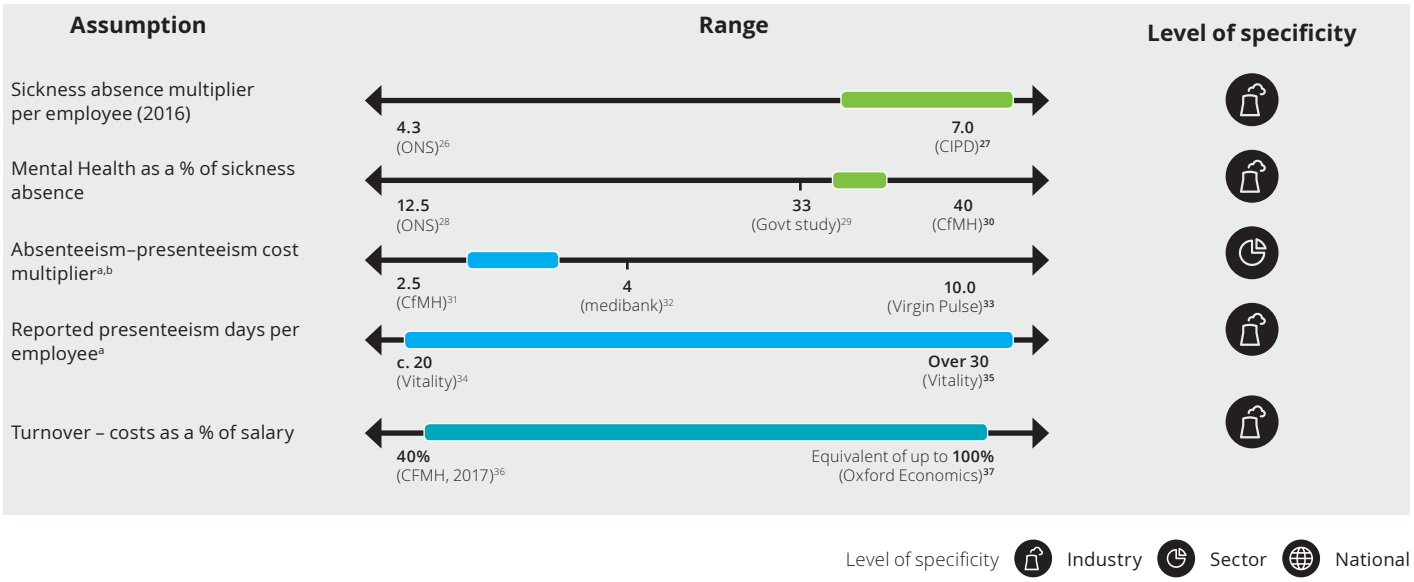
Figure 19. Breakdown of costs and considerations around inclusion in this report



Assumptions

There are a range of assumptions linked to our cost model. In order to select the most relevant assumptions, we judged the reliability and methodology behind sources to reach final assumptions, or ranges of assumptions.

Figure 20. Assumptions made



Notes: Multiple sources and assumptions used for cost modelling, therefore individual trends may not fully triangulate with final cost numbers

a – These two sliders represent different methodologies for reaching presenteeism; b – No industry split available but sector split used

What is the ROI of workplace mental health intervention?

The return on investment of workplace mental health interventions is overwhelmingly positive. Based on a systematic review of the available literature, ROIs range from 0.4:1 to 9:1, with an average ROI of 4.2:1. These ranges account for a number of data sources and methodologies. Our research indicates that these figures are likely to be conservative given the declining cost of technology interventions over time, increase in wages, cross-country differences and limited consideration of the full breath of benefits. There are opportunities for employers to achieve better returns on investment by providing more interventions at organisational culture and proactive stages, enabling employees to thrive, rather than intervening at very late stages.

Our research suggests a conservative ROI range of 0.4:1 to 9:1 based on the most reliable sources found in our systematic review. Since these are all older studies, further research would be helpful. We consider these figures to be conservative for a number of reasons:

- Many do not consider the impact on the wider workforce or all elements of absence, presenteeism and turnover costs
- Key studies were published between 2007-2013, since which time technology costs have fallen and wages have risen
- Many studies do not consider wider benefits to society in the form of reduced National Health Service costs, social welfare costs and economic opportunity cost due to greater output[a]
- Studies are from a range of countries with different costs

Across these studies, the following factors have been shown to impact the ROI of mental health interventions:

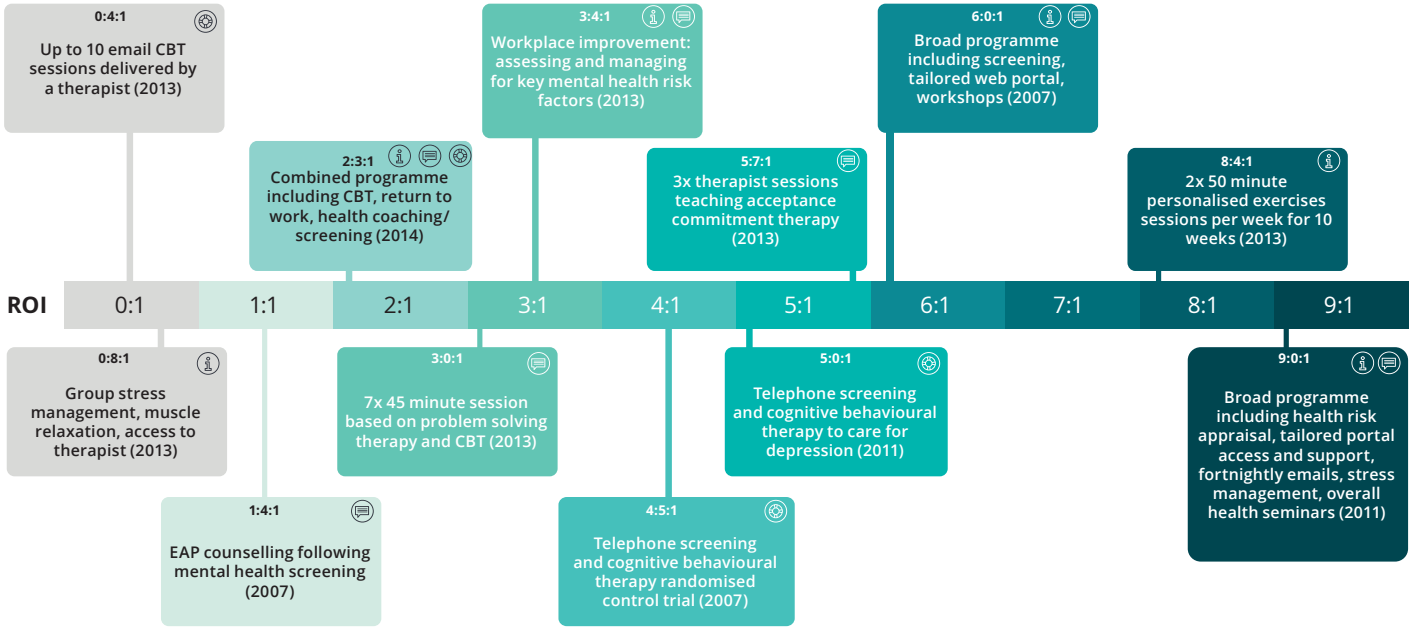
- Limited 1-1 delivery of professional expertise, with a focus on organisation-wide activities
- Use of technology to reduce cost and increase likelihood of uptake by limiting impact of stigma
- Use of diagnostics to target interventions based on need

These factors also map to the stage at which interventions are delivered. This means that organisation-wide, preventative activities which improve employee resilience can achieve a higher return on investment than reactive, individual-focused activities.

Figure 21. Intervention types linked with employee journey

Key	Intervention type	Maximum ROI	Example intervention(s)
	Reactive (1-1) mental health support	5:1	Therapy with a licensed mental health practitioner
	Proactive mental health support	6:1	Line manager workshops, health coaching
	Organisation-wide culture/awareness raising	8:1	Tailored web portals, personal exercise sessions

Figure 22. Summary of high confidence sources



Note: a – With the exception of the Matrix (2013) study

ROI methodology

There have been limited and conflicting studies around the ROI of mental health interventions. We conducted a systematic review of over 100 reports, in order to understand the range of ROI values associated with the highest quality papers.

A systematic review was conducted to understand the return on investment of mental health interventions using the following steps:

1. Keyword search using a combination of phrases linked to mental and emotional health and wellbeing, the workplace and ROI analysis via Google and Google Scholar.
2. Exclusion of reports which could not be linked to either mental health, the workplace or provided quantitative data on costs and benefits to leave 23 reports with quantitative information.
3. Review of useful reports based on hierarchy of evidence base and understanding linkage between reports (see Appendix 3) to leave 7 high confidence reports.
4. ROI evaluation of primary reports to reveal final, high-confidence ROI ranges.

In the next page we explore Stage 3 and 4 in more detail. For more detail on the 23 reliable reports (including interventions, cost and benefit considerations) and the link between primary and secondary reports, further details can be found in the Appendices. We have also provided a deep-dive on a 2013 report which illustrates the ROI of various interventions to the healthcare system, social welfare system, economy as well as employers. However, it is recommended to consider these figures in the context of the overall findings of the systematic review as they are only one of several sources on this matter and have been questioned by experts.

Figure 23. Systematic review methodology[a]

Keyword search

Research using Google and Google Scholar to find publications on the following search terms:

"Return on investment for..."
"Cost-benefit analysis of..."
"Business case for..."
"Investment case for..."
"Financial case for..."
"Commercial benefits of..."
"Financial benefits of..."
"Business benefit of..."
"Payback for..."
"Profitability of..."

...mental health interventions in the workplace"

Search repeating using *"mental wellbeing"* and *"emotional wellbeing"* in place of *"mental health"* and *"initiatives"* and *"programmes"* in place of *"interventions"*

>130 reports reviewed and catalogued

Based on the relevance of key words searched we selected >130 reports for review

These reports were then sorted as below:

Rejected, due to:

- Lack of specific relevance to mental health interventions
- Lack of specific relevance to the workplace
- Lack of ROI quant data

Accepted

- Relevant ROI quant data or other financial benefits of mental health interventions in the workplace.
- **28 relevant specific reports identified**

Review of source material behind 28 specific reports

The 28 relevant reports were interrogated in more detail to find the most useful information which offered:

- Specificity of ROI data
- Clarity of methodology used to establish the quoted ROI figures
- Links to primary source material from which ROI data had been derived/cited (where appropriate)
- **23 reliable reports were identified as having useful ROI specific data**

23 reports were included as they were identified as having reliable ROI specific data

Deep dive into the primary source data and studies used in the 23 reports to sort the sources into higher/lower confidence brackets.

Higher/lower confidence sources have been sorted by:

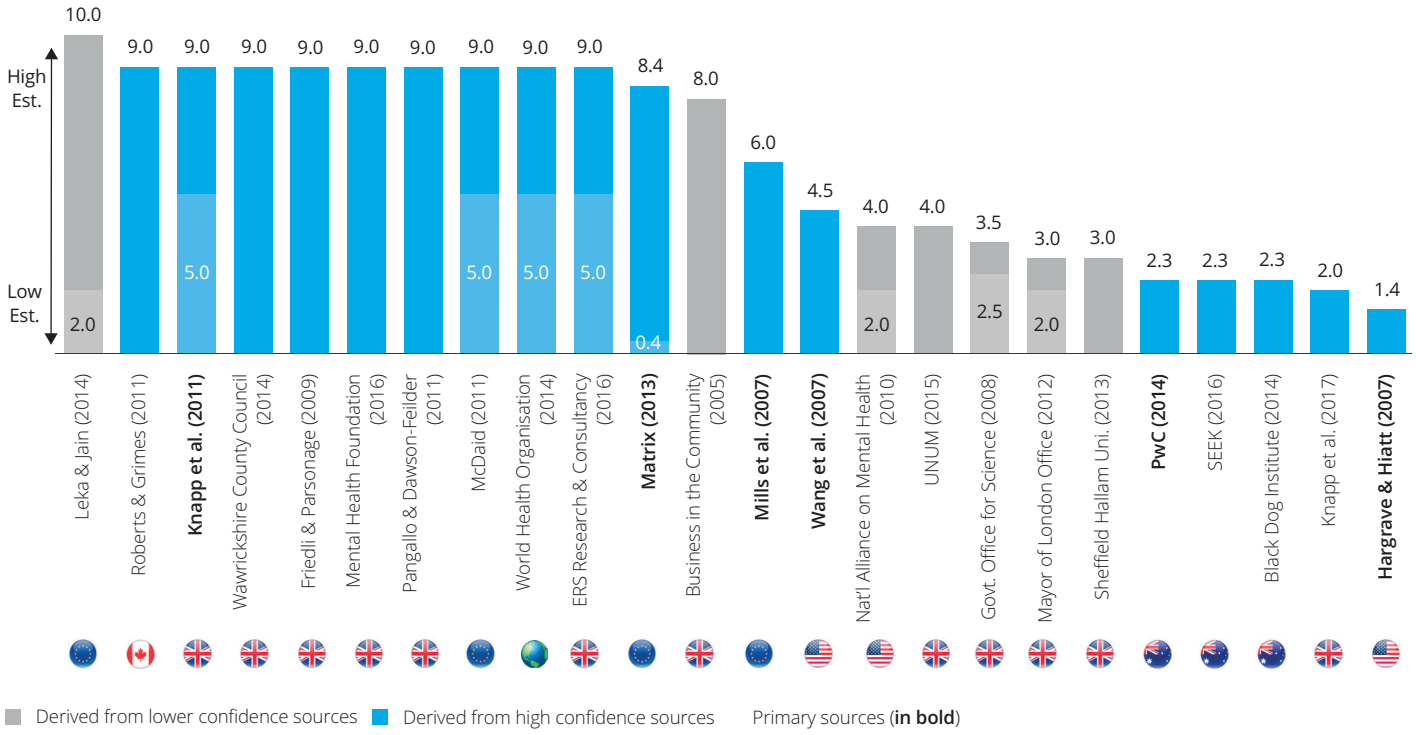
- Hierarchy of evidence base (systematic review = high/case report = low)
- Frequency of citation in secondary and tertiary reports
- Clarity of methodology used to calculate ROI
- Detail on the specific interventions and their impacts
- **Finally, 7 primary studies/sources identified as high confidence offering an ROI range of 0.5:1 – 9.5:1**

Note: a – This is an illustrative, non-exhaustive list of mental health ROI papers

ROI ranges

Our research into the 23 'reliable' reports show that interventions are overwhelmingly positive, however the range of ROIs vary significantly. This range is even seen within individual reports. Figure 24 below shows the range of low and high ROI estimates within each report. The reports in grey show the numbers derived from lower confidence sources.[a]

Figure 24. Step 3. ROI ranges and consideration of high vs. low confidence sources

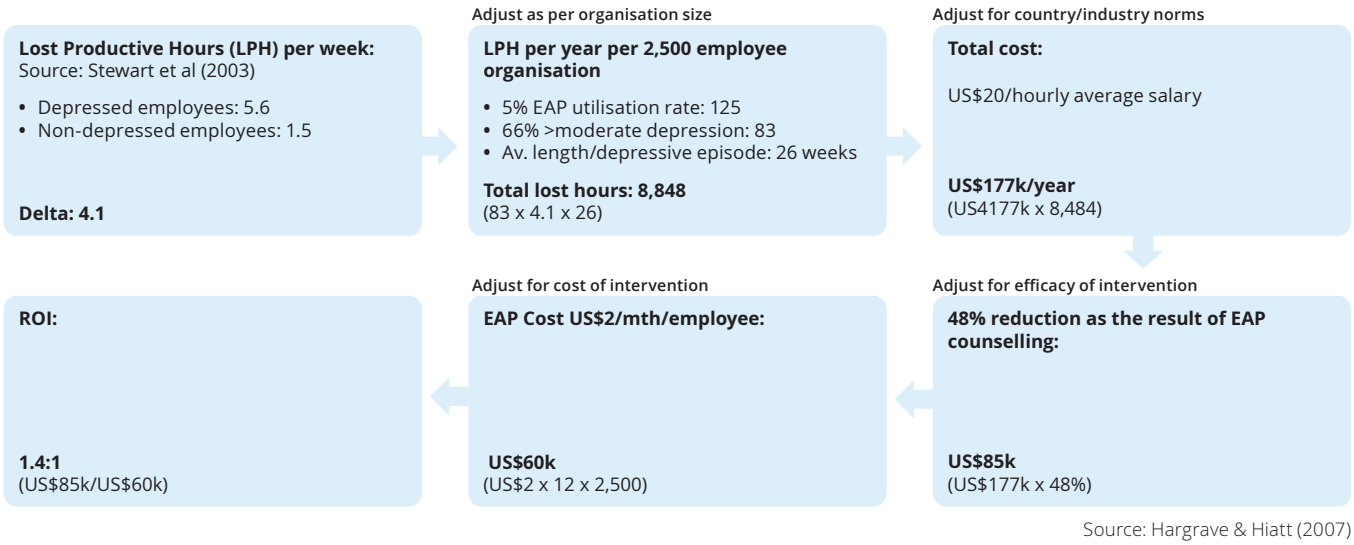


Derived from lower confidence sources Derived from high confidence sources Primary sources (**in bold**)

ROI calculations

The calculation of ROI involves either collecting data or using a series of assumptions from other reports. An example can be seen below, and for more information on how studies link together please see Appendix 2.

Figure 25. Step 4. Example ROI calculation for primary sources



Source: Hargrave & Hiatt (2007)

Note: a – Please note some sources quote the same studies

Deep Dive: ROI by intervention (Matrix 2013[38])

Matrix was commissioned by the European Agency for Health and Consumers (EAHC) and DG Health and Consumers (SANCO) to assess the potential contribution that mental health promotion and mental disorder prevention programmes can make to the EU-policy objectives of promoting the sustainability of health and social welfare systems, increasing the employment rate and increasing economic productivity.

As such the study included a review of existing scientific literature and the creation of an economic model to answer five key questions:

1. **What are the major past and expected future trends in public and workplace mental health and illness in the EU?**

   The review found that mental disorders today significantly impact workers, estimated to cost the EU25 €136.6bn per annum (McDaid, 2008); they believed these costs were likely to grow as an aging population put increasing pressure on the labour force.

2. **What is the economic impact of mental disorders on health and social welfare systems, employment and productivity in the EU?**

   The study estimated the cost of work-related depression in the EU27 to be close to €620bn pa, made up of:

   - Absenteeism and presenteeism – €270bn
   - Lost economic output – €240bn
   - Healthcare costs – €60bn
   - Social welfare payments – €40bn

3. **What type of workplace mental health promotion and mental disorder programmes are available? What is their economic return on investment? What is their impact on health and social welfare systems, employment and productivity?**

   The study grouped workplace mental health interventions into three categories by the type of population they were aimed at: universal, targeted and treatment programmes. The studies used strongly suggested that implementing a mental health programme would have significant improvements in absenteeism and productivity in the workplace (see table below), but due to the range of programmes and different methodologies used could not recommend one particular intervention, instead suggesting that this be tailored to each organisation.

4. **What is the role of health and social welfare systems in workplace mental health promotion and mental disorder programmes?**

   Studying a sample of four Member States suggested that measures should be a collaborative effort across Government departments such as those in charge of health, occupational safety and health and social welfare systems and that no one department can take full responsibility in order to be implemented effectively.

5. **What would be the contribution of mainstreamed workplace mental health promotion and mental disorder programmes to realising EU-health, social and economic policy objectives?**

   The review's results suggested that the net economic benefits generated by workplace mental health interventions over a 1 year period could range from €0.81 to €13.62 for every €1 of expenditure by the employer. The net economic benefits were found to range from -€3bn to 135bn in terms of reduced costs and lost output. However, the review found that some interventions could not be afforded by the employer alone and so recommended additional funding or the creation of incentives. The review also found that the ROI depended on contextual factors such as the wider societal perceptions of mental health but under sensitivity testing found that the interventions studied still represented a good economic investment, even when their positive impact was reduced by 50-75%.

Figure 26. Summary of benefits and costs of mainstreamed programmes by sector over a 1 year period[a]

	Without Programme	Universal		Targeted		Treatment	
		Workplace Improvement (WI)	Acceptance & commitment therapy (ACT)	Stress Management (SM)	Email CBT (ECBT)	Exercise (Ex)	CBT
Effects							
Effect on depression rate	-	-34%	-80%	-45%	-25%	-72%	-43%
Programme costs							
Cost of programme per person	-	€15.8	€68.2	€487.8	€478.0	€722.8	€1,204.9
Cost of programme	-	€3bn	€11bn	€14bn	€14bn	€11bn	€18bn
Opportunity cost of recipients' time	-	€28bn	€22bn	€4bn	€2bn	€4bn	€2bn
Costs by sector							
Healthcare system	€63bn	€56bn	€46bn	€61bn	€62bn	€44bn	€52bn
Social welfare system	€39bn	€38bn	€36bn	€39bn	€39bn	€36bn	€37bn
Economy	€242bn	€229bn	€212bn	€237bn	€239bn	€209bn	€222bn
Employers	€272bn	€235bn	€186bn	€257bn	€263bn	€178bn	€215bn
Total costs	€617bn	€558bn	€480bn	€593bn	€603bn	€467bn	€527bn
Benefits							
Net benefit	-	€28bn	€103bn	€6bn	-€3bn	€135bn	€70bn
Net benefit per person	-	€171	€631	€202	-€90	€9,125	€4,708
Benefit-cost ratio by sector							
Healthcare system	-	€2.94	€1.60	€0.20	€0.11	€1.80	€0.64
Social welfare system	-	€0.47	€0.26	€0.03	€0.02	€0.29	€0.10
Economy	-	€5.03	€2.73	€0.37	€0.21	€3.12	€1.12
Employers	-	€3.36	€5.66	€0.81	€0.47	€8.42	€3.04
Overall benefit-cost ratio	-	€11.79	€10.25	€1.41	€0.81	€13.62	€4.91

Note: a – ROI calculations do not include the cost of people's time under costs, and if calculated differently, considering benefits against cost of intervention and the cost of employee's time may change cost-benefit ratios, particularly those of universal interventions

What can we learn from international examples?

There are a number of lessons we can draw from other countries in relation to employers and mental health and wellbeing. Looking across Germany, Canada, Australia, France, Belgium and Sweden reveals a range of interventions and approaches in this space. Examples of good practice in Germany, Canada and Australia suggest that providing a common framework around mental health interventions and engaging with key stakeholders can empower employers to implement the most helpful interventions for their workforce. On the other hand, France, Belgium and Sweden have focused on legislation to protect employee mental health and wellbeing.

Germany has developed a robust mental framework 'Arbeitsprogramm psyche', one of three pillars of the Joint German Occupational Safety and Health Strategy (GDA), driven by German Government and insurance institutions. It aims to implement measures to reduce health risk caused by stress[39].

Canada provides a structured framework for mental health wellbeing in the workforce, with heavy Government involvement in developing the National Standard of Canada for Psychological Health and Safety in the Workplace (the Standard), a unique set of voluntary guidelines, tools and resources across Canada, intended to guide organisations in promoting mental health and preventing psychological harm at work.[40]

Australia has developed a very strong mental health alliance to provide a vast amount of resources, strategies and guidelines for the most important actors in the workforce.[41]

More detail on the actions taken by these three countries can be found in the deep-dives, followed by key insights from France, Belgium and Sweden.

Deep Dive 1: Germany

The 'Arbeitsprogramm psyche' initiative

The 'Arbeitsprogram Psyche' initiative focuses on providing information and good practice examples and implementing psychosocial risk assessment in the workplace. It is a nationally-led programme, in partnership with company stakeholders, federal and national ministries, and insurance companies, designed to reduce work-related stress, comprised of four key parts:

Information, sensitization and motivation	Qualification	Support	Control
• To inform employees and employers • To motivate employers to prevent or optimise work-related mental load • To inform the public via newspapers and other media • To create a central homepage covering all aspects of work-related mental load	• To qualify 6000 German labour inspectors in the field of psychological stress and strain at work with the competences they need to support and supervise enterprises • To qualify occupational physicians and health and safety officers (OSH) responsible for consulting enterprises • To organise an exchange of experiences between the specialists for work-related mental load in the labour inspectorates • To qualify employers and employees in measures carried out by their organisations (trade unions, employers' associations, but also by social accident insurance institutions)	• To create guidelines for suitable procedures of considering psychological stress in workplace risk assessments • To collect and disseminate examples of good practice about prevention of work related mental load • To work out practicable instruments for measuring psychological stress and strain at the workplace • To identify functions and occupations with a high risk of work-related mental load	• To set a target of at least 10.000 enterprises in order to be reviewed between 2015 and 2017 • The main subjects of the reviews will be: – The integration of mental load in the assessment of working conditions – Long working hours or work in the night – The risk of traumatisation by accidents or violence

A key element in the delivery of this program is the activation and inclusion of companies, social partners and other cooperation partners, e.g. the health insurance funds and the trade associations/federations of company doctors and specialists for occupational safety and health, due to their extensive experience in reduction of mental and behavioural disorders

Source: Joint German Occupational Safety and Health Strategy (GDA)

Deep Dive 2: Canada

The Psychological Health and Safety Management System

The Psychological Health and Safety Management System (PHSMS) is a nationally-agreed mental health framework that over 40 employers across the country have signed up to. It is a comprehensive framework resulting in tailored interventions built on a nationally agreed five-step framework.

The 5-step framework is nationally agreed...

1. **Commitment, leadership, and participation:** Ensure that the responsibilities and authorities related to the PHSMS are defined and communicated throughout the organisation
2. **Planning:** Identify and prioritize work-related psychological health and safety hazards, risks, legal requirements, management system gaps, and opportunities for improvement
3. **Implementation:** Provide and sustain an infrastructure and resources to achieve conformity to the Standard, including preventive and protective measures related to hazards and risks.
4. **Evaluation and corrective action:** Establish and maintain procedures to monitor, measure and record psychological health and safety conformance and the effectiveness of the PHSMS
5. **Management review and continual improvement:** Establish and maintain a process of scheduled management reviews of the PHSMS and the degree to which objectives have been achieved

...but with the freedom to implement a series of effective interventions in the workplace, such as the examples below:

- Enhanced the company intranet to provide information to all staff about workplace health and safety issues, policies and programs
- Created a College Code of Conduct establishing expectations for interpersonal behaviour on campus and describing the process for reporting harassment and bullying
- Introduced a training program for managers, staff and faculty to facilitate communication and productive conflict resolution
- Introduced The Working Mind program for all staff to promote mental health and reduce the stigma of mental illness
- Created a "Change Management" taskforce to support work teams and workers with issues arising from a merger, such as changes in reporting, team mandates and job roles

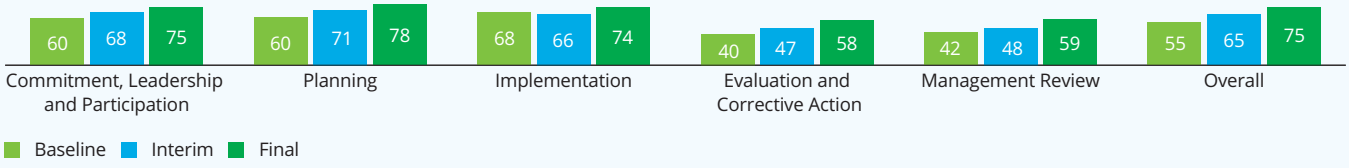
Source: Mental health commission

Progress with *The Standard*

On average, participating organisations achieved 725 compliance with the five elements of the *Standard*, namely Commitment, Leadership and Participation, Planning, Implementation, Evaluations and Corrective Action, Management Review. This compares to 55% compliance at baseline stage.

34/40 participating pilot organisations have implemented *The Standard* fully across their organisation.[42, 43]

Figure 27. Pilot organisations' Standard implementation scores



Pilot Company Example 1	
Company	**Goodhealth**
Context	Healthcare provider (2,500 employees), that is the result of the amalgamation of 3 previously separate providers.
Actions	• Enhance online resources on the Intranet relating to workplace health and safety policies and programmes • "Change team" created to support employees through the transition of the merger • Enhanced and consistent access to psychological supports e.g. EFAP • "Working Alone" policy including 24/7 security and site-wide emergency call boxes • Revised Employee Incident Report system with mandated 3 month follow-up to deal with psychological threats • Low cost onsite day care provided to help work-life balance
Results	The number of incidents related to psychological health and safety, which had been steadily increasing, Stabilized

Pilot Company Example 1	
Company	**Best ED**
Context	• BestEd is a community college providing vocational upgrading and technical training. It has more than 1,100 students and approximately 120 faculty and staff.
Actions	• Initiated a job demands analysis that considered the psychological and technical skills necessary for each position • Created a College Code of Conduct establishing expectations for interpersonal behaviour on campus and describing the process for reporting harassment and bullying • Introduced a training program for managers, staff and faculty to facilitate communication and productive conflict resolution • Introduced The Working Mind program for all staff to promote mental health and reduce the stigma of mental illness • Expanded the benefits program to include family members and enhanced coverage for psychological services
Results	• 35% EAP utilisation • 55% reduction in harassment and bullying complaints

Source: Case study research project findings: The National Standard Of Canada for Psychological Health and Safety In the workplace 2014-2017

Deep Dive 3: Australia

The Mentally Healthy Workplace Alliance in Australia provides strategy tips and resources for all major actors in the workplace:

EMPLOYERS ORGANISATIONS

Steps to developing a successful mental health strategy in large organisations

- Gain leadership support
- Identify needs
- Develop a plan
- Monitor, review and improve

MANAGERS

Strategy and resources for managers to mentally support other employees

- Protect the employee's right to privacy and confidentiality
- Communicate information updates to the team regularly
- Manage the impact of any absences on the team and distribute the workload appropriately

EMPLOYEES

Strategies and resources for individuals wellbeing in the workforce

- Gain leadership support
- Identify needs
- Develop a plan
- Monitor, review and improve

SMALL BUSINESSES

Steps to create a mentally healthy small business

- Identify priority areas
- Identify actions as part of the plan
- Monitor, review and evaluate

Tips to create a healthy small business:

- Make decisions autonomously
- Respond quickly to difficult situations
- Communicate regularly and easily with staff members
- Introduce initiatives and strategies that are meaningful to your staff

...with the freedom to implement a series of effective interventions in the workplace, such as the examples below

- Promoted mental health and wellness at the workplace with flexible working hours and remote working opportunities
- Provided employees access to a company doctor in addition to their EAP
- Allowed staff to attend educational and training opportunities ranging from topics on people development (e.g. upskilling) to professional development seminars (e.g. superannuation and Certificate IV training for frontline management)
- Provided all staff with general training in mental health, such as mental health first aid programs
- Introduced a set of interventions specific for law employees around mental health first aid training, partner mental health awareness workshops and 'building resilient careers' workshops known as 'Resilience@law'

Source: HeadsUp.org

Interventions in France, Sweden and Belgium

There are a number of additional interventions in France, Sweden and Belgium which protect employee mental health and wellbeing through legislation. The impact of these interventions has not yet been reported.

French interventions on mental health focus mainly on improving work-life balance and flexible working conditions. Additionally, in 2017, the 'right to disconnect' was adopted to avoid burnout, with employees having the legal right not to check/reply to emails during their time off.[46]

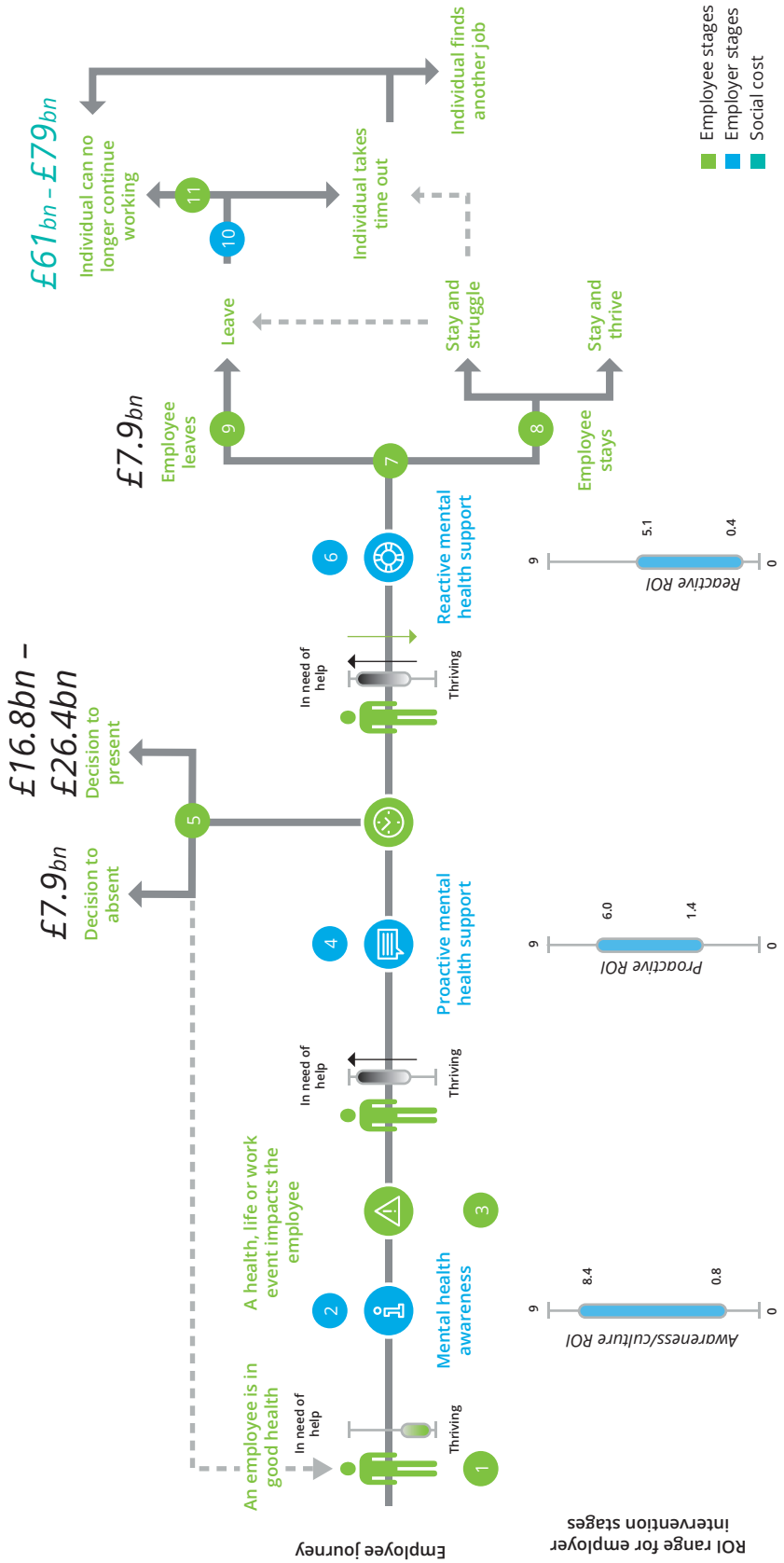
To support small enterprises to meet their regulatory obligation to assess psychosocial risks (PSR), French public authorities have developed a collective questionnaire tool – "Faire le point", that pinpoints PSR factors that have been overlooked by the participating company and provides an action plan for companies by answering 41 multiple choice questions.

Scandinavian countries, notably Sweden, have some Government involvement with improving effects on employment and mental health. However, there is some room for development of the overall capacity of the mental health system in the workforce. For example, increasing the resources to deal with mental health issues. In order to improve employee work-life balance, Sweden has experimented with six-hour working day. Sweden is also one of the most generous countries across OECD with parental leave – a couple can split 480 days however they choose and receive 80% of their normal pay during that time. Ninety of those days are reserved just for fathers, and none of the time expires until the child turns 8.[47]

Belgium has recently enhanced its employment legislation to prevent psychoanalysis risks in the workforce and is going through major prevention programmes on employee burnout (a feeling of exhaustion and hopelessness brought on by prolonged exposure to stress in the workplace) – in 2014, legislation was passed to include burnout as an officially recognised psychosocial risk, similar to bullying, harassment and violence in the workplace. Employers are therefore responsible for conducting risk analyses and counselling employees in order to avoid burnout. [48]

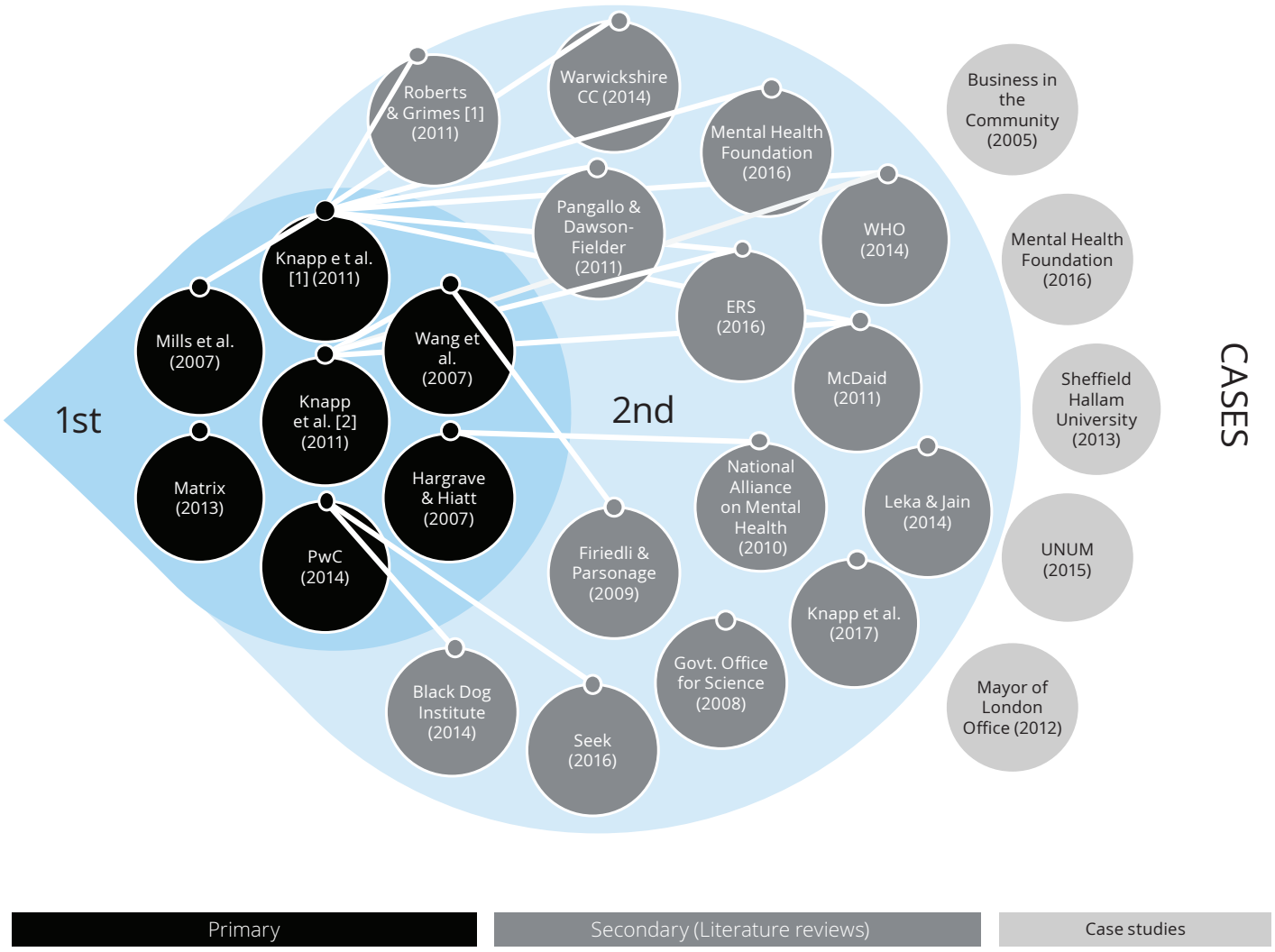
Appendices

Appendix: 1. Employee journey



Appendix: 2. ROI literature review mapping

We have observed a considerable degree of overlap and circular referencing of key sources, shown in the literature mapping below, where primary sources are shown in the left corner, with lines to indicate where secondary literature reviews sources have drawn upon or referred to primary studies. In the outer, right side, case studies of specific businesses are shown, that provided valuable additional evidence but were too narrow-reaching to be used in our review.



Appendix: 3. Detailed ROI report summary

We examined each 'useful' report to determine ROI and consider primary sources

Year	Author	Country	ROI	Report type	Intervention	Cost	Size of trial	Reported benefit	Original Source	Source methodology
2014	Leka & Jain	Europe	10:1	Literature Review	Mental health promotion programmes general	–	–	Absenteeism	Kleinshmidt (2013)	–
2011	Roberts & Grimes	Canada	9:1	Literature Review	**A multi-component health promotion intervention, including:** • Health Risk Appraisal • Personalised health and well-being report with wellness score a tailored advice • Access to a personalised health, well-being and lifestyle web portal, including articles, assessment and interactive online behaviour-change programmes • Tailored fortnightly emails • X4 paper-based packs on 4 most prevalent health risks: stress management, sleep improvement, nutritional balance and physical activity plus x4 on-site seminars on these issues	£40,000	500	Absenteeism and presenteeism	Knapp et al. (2011) [1]	Simulated model drawing on data from a previously conducted "before-after intervention-control" study (Mills, 2007)
2011	Knapp et al.	UK	9:1	Literature Review						
2014	Wawrickshire County Council	UK	9:1	Literature Review						
2016	Mental Health Foundation	UK	9:1	Literature Review						
2011	Pangallo & Dawson-Feilder	UK	9:1	Literature Review						
2011	McDaid	Europe	9:1	Literature Review						
2014	World Health Organisation	Global	9:1	Literature Review						
2016	ERS Research & Consultancy	UK	9:1	Literature Review						
2013	Matrix [1]	Europe	8.4:1	Simulated model	**Exercise programme:** • Participants were given two 50 minute personalised exercise sessions per week for 10 weeks.	€723/ emp.	–	Absenteeism	de Zeeuw (2010)	–

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Year	Author	Country	ROI	Report type	Intervention	Cost	Size of trial	Reported benefit	Original Source	Source methodology
2005	Business in the Community	Europe	8:1	Case Study review	**London Underground's Stress Plan:** • Stress Reduction Programme and a Manager's Toolkit. • The toolkit includes stress guides for managers and employees, and advice cards on conducting back to work interviews. • A CD, which is made available to staff with information and several relaxation exercises	–	–	–	NA	–
2007	Mills et al.	UK	6:1	Quasi-experimental 12-month before-after intervention-control study	• A multicomponent health promotion program incorporating a health risk appraisal questionnaire, access to a tailored health improvement web portal, wellness literature, and seminars and workshops focused upon identified wellness issues.	£70/ emp.	618	Absenteeism and presenteeism	NA Primary study	N/A

Appendix: 3. Detailed ROI report summary

We examined each 'useful' report to determine ROI and consider primary sources

Year	Author	Country	ROI	Report type	Intervention	Cost	Size of trial	Reported benefit	Original Source	Source methodology
2013	Matrix [2]	Europe	5.7:1	Simulated model	**Acceptance commitment therapy:** • Three group education sessions with a therapist teaching how participants to experience or accept undesirable thoughts, feelings and physical sensations without trying to change, avoid or otherwise control them	€68/emp.	–	Absenteeism	Bond (2000)	–
2011	McDaid	Europe	5:1	Literature Review	**Workplace-based enhanced depression care consisting of:** • Completion by employees of a screening questionnaire, followed by care management for those found to be suffering from, or at risk of developing, depression and/or anxiety disorders. • Those identified as being at risk of depression or anxiety disorders are offered a course of cognitive behavioural therapy (CBT) delivered in six sessions over 12 weeks.	£20,676	500	Absenteeism and presenteeism	Knapp et al. (2011) [2]	Simulated model drawing on data from a previously conducted Randomised Control Trial (Wang et al. 2007)
2014	World Health Organisation	Global	5:1	Literature Review						
2016	ERS Research & Consultancy	UK	5:1	Literature Review						

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We examined each 'useful' report to determine ROI and consider primary sources

Year	Author	Country	ROI	Report type	Intervention	Cost	Size of trial	Reported benefit	Original Source	Source methodology
2007	Wang et al.	USA	4.5:1	Randomised control trial	**Telephone Outreach, Care Management, and Psychotherapy:** • Systematic assessment treatment • Entry into in-person treatment (both psychotherapy and antidepressant medication), monitored and supported treatment adherence. • Telephone psychotherapy intervention for hose declining in-person treatment • This included psycho-educational workbook emphasizing behavioural activation, identifying and challenging negative thoughts, and developing long-term self-care plans. • Those experiencing significant depressive symptoms after 2 months were offered an 8-session CBT program.	US$1,800/ emp.	604	Presenteeism	NA – Primary study	NA
2009	Friedli & Parsonage	USA	4.5:1	Literature Review	• As above				Wang et al. (2007)	Randomised control trial
2010	National Alliance on Mental Health	USA	2:1 4:1	Literature Review	Employee Assistance Programmes (EAP)	–	–	Absenteeism and presenteeism	Hargrave & Hiatt (2007)	Pre/post-treatment survey study

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We examined each 'useful' report to determine ROI and consider primary sources

Year	Author	Country	ROI	Report type	Intervention	Cost	Size of trial	Reported benefit	Original Source	Source methodology
2015	UNUM	UK	4:1	Case study review	**Oracle EAP Case Study:** • Established a network of wellbeing champions across the business • Resilience workshop series: 540 employees attended. • In addition, Oracle brings all its wellbeing providers together for a quarterly Wellbeing Partner Forum, at which data is shared. Participants include its healthcare plan and insurance companies, occupational health and Employee Assistance Programme (EAP) providers.	£250,000	–	–	NA	–
2008	Govt. Office for Science	UK	2.5:1	Project Report Paper	• Flexible working allowance for employees with children under the age of 18	£66,000,000	–	Presenteeism	Foresight Paper (2008)	–
			3.5:1		• Flexible working allowance for all employees	£71,000,000				

Appendix: 3. Detailed ROI report summary

We examined each 'useful' report to determine ROI and consider primary sources

Year	Author	Country	ROI	Report type	Intervention	Cost	Size of trial	Reported benefit	Original Source	Source methodology
2013	Matrix [3]	Europe	3.4:1	Simulated model	**Workplace improvement programme:** • Engages employees and supervisors to assess the work environment for potential risk factors which could cause poor mental health. Composed of a training workshop for facilitators co-ordinating the intervention, supervisor education workshop and three workshops assessing the work environment and implementing the necessary changes.	€16/emp.	–	Absenteeism	Tsutsumi (2009)	–
2012	Mayor of London Office	UK	2.5:1	Literature Review	–	–	–	–	Lee et al. (2010)	–
			2.7:1	Case study review	**Johnson & Johnson case study:** • A comprehensive wellness programme that focuses on: Mental health and well-being, Occupational health and benefit design, Healthy lifestyle, Health education and awareness	–	–	–	NA	–
			3.3:1	Literature Review	–	–	–	–	Baicker et al. (2010)	–
			4:1							

Appendix: 3. Detailed ROI report summary

We examined each 'useful' report to determine ROI and consider primary sources

Year	Author	Country	ROI	Report type	Intervention	Cost	Size of trial	Reported benefit	Original Source	Source methodology
2013	Matrix [4]	Europe	3:1	Simulated model	**Problem solving therapy with Cognitive behavioural therapy:** • Seven sessions 45 minutes sessions of therapy based on the principles of PST and CBT	€1,205/emp.	–	Absenteeism	Lexis (2011)	–
2013	Sheffield Hallam University	UK	3:1	Case study review	**Sheffield teaching hospitals pilot case study:** • The programme included individualised health checks, lifestyle management advice, one-to-one coaching and educational workshops to raise awareness on topics including exercise, healthy eating, mental wellbeing and resilience.	£13,200	50	Absenteeism	NA	–
2017	Knapp et al	UK	2.0:1	Simulated model	**Universal CBT program** • Employees were offered 12 1-hour CBT sessions and other support.	£6,986	1,000	Absenteeism, presenteeism, turnover	NA	Simulated model drawing on workplace wellbeing program offering CBT intervention to employees of a Welsh City Council

Appendix: 3. Detailed ROI report summary

We examined each 'useful' report to determine ROI and consider primary sources

Year	Author	Country	ROI	Report type	Intervention	Cost	Size of trial	Reported benefit	Original Source	Source methodology
2014	PwC	Australia	2.3:1	Simulated model	**7 stage programme:** 1. Workplace physical activity programmes 2. Coaching and mentoring 3. Mental health first aid and education 4. Resilience training 5. CBT bases return-to-work programs 6. Well-being checks or health screenings 7. Encouraging employee involvement		–	Absenteeism and presenteeism	PwC	Simulated model
2014	Black Dog Institute			Literature review						
2016	SEEK			Literature review						
2007	Hargrave & Hiatt	USA	1.4:1	Pre/post-treatment survey analysis and simulated model drawing on primary research previously conducted (Stewart et al, 2003)	**EAP counselling**: • Measured the impact on depression of in-person EAP counselling for employees who screened positive for moderate or greater levels of depression.	US$2/emp./mth	>11,000	Presenteeism	NA – Primary study	NA

Appendix: 3. Detailed ROI report summary

We examined each 'useful' report to determine ROI and consider primary sources

Year	Author	Country	ROI	Report type	Intervention	Cost	Size of trial	Reported benefit	Original Source	Source methodology
2013	Matrix [5]	Europe	0.8:1	Simulated model	**Stress management programme**: • Participants attended one group stress management session and one muscle relaxation session, each lasting two hours. Following these sessions, participants had access to a therapist via work email for individual counselling	€488/emp.	–	Absenteeism	Mino (2006)	–
	Matrix [6]		0.5:1		**Email CBT** • Intervention consisted of seven phases of CBT delivered entirely through email communication by a therapist. Each phase took participants one week to complete, with 10 feedback emails from the therapist per participant	€478/emp.	–	Absenteeism	Ruwaard (2007)	–

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