MENTUPP

Situation analysis

Document date: 30.03.2021
Document version: 2.0
Deliverable No: D4.1

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Situation analysis

Version History

Version number (date)	Details
1.0 (06.11.20)	Initial submission to EC
2.0 (30.03.21)	Changed MINDUP to MENTUPP throughout the deliverable Minor change in section 4.2 and Appendix 2 to correct country error (Albania corrected to Kosovo)

Table of Contents

1 Executive Summary

This Deliverable D4.1 is the Situational analysis developed in WP4 Task 4.1. It contains the results of the collection of best practices and the lessons learned from the data collected through the systematic review and Delphi questionnaire. These results will be used to produce, update and fine tune the tools for the anti-stigma materials developed in WP4 of the MENTUPP project.

The systematic review includes studies that have fulfilled the search criteria defined to identify the relevant interventions addressing attitudes towards mental health issues, especially depression, anxiety, stress and suicidal behaviour in occupational settings. We analysed trials of different kinds of interventions (online and face to face), different levels of employment (employee, supervisor, manager) from various sectors. The findings were mixed, ranging from studies demonstrating little change in attitudes towards stigma to studies showing a significant change in attitudes towards stigma. The studies regarding stigma in the workplace are mainly from Australia, Canada, and the UK, with 1 study each from Germany and Japan.

The collection of anti-stigma organisations and best practices consists of initiatives obtained from seven countries in the MENTUPP project. Most of them are initiatives addressing mental health as a whole or some specific disorders (especially depression) with destigmatisation as one of their aims. The practices aim to increase the knowledge about mental health and destigmatise those people affected by mental health issues. There are also organisations standing up for wider range of rights of people or clients, where improvements in mental health are not the specific aim but are also included as an additional objective. The experts in the Delphi report mentioned the initiatives known by them – the difference between the existing initiatives and the initiatives mentioned by the Delphi experts demonstrates the lack of information and dissemination in the area of stigma interventions. The collection reveals the need for anti-stigma programmes tackling the lack of knowledge and misconceptions about people living with mental health issues.

The Delphi report (assessed among experts of the three sectors, health, construction and ICT) demonstrates that there are many unmet needs considering the implementation of workplace-based anti-stigma and anti-discrimination programmes and the relevance of developing the MENTUPP interventions, the results also demonstrated that important challenges remain in terms of implementation. The experts agreed with various well-defined needs and strategies to fulfil them in the area of anti-stigma interventions. Most of the experts reported that there are few or no actions considering stigma in the workplaces, especially in SMEs in all three sectors. They also reported many possible benefits of workplace-based anti-stigma interventions, but concerns were also raised about the concrete steps of implementation. The current COVID-19 pandemic underlines the need for the MENTUPP tools planned and being produced for the Anti-Stig Harbour in Task 4.2.

2 Introduction & Background

MENTUPP aims to improve mental health and wellbeing in the workplace by developing, implementing and evaluating a comprehensive, multilevel intervention targeting both clinical (depressive, anxiety disorders) and non-clinical (stress, burnout, wellbeing, depressive symptoms) mental health issues, as well as combating the stigma of mental (ill-) health. WP4 collects scientific and practical background and produces the tools in order to reduce stigma in the workplace.

WP 4 focuses on the development of anti-stigma tools. The process includes interventions that reduce the stigma of depression, comorbidities, and suicidal behaviour in the workplace, for the purpose of MENTUPP component C: destigmatisation of mental health in the SMEs' workplace.

WP4 reviewed anti-stigma best practices and conducted a consultation process with academic experts and partners in construction, health, and ICT SMEs across the MENTUPP intervention countries through the Delphi survey. In addition, based on the European Framework for Action on Mental Health and Wellbeing and EAAD, evidence-based and best practice materials and interventions addressing stigma related to mental health in the workplace and gender specific challenges, were reviewed and updated.

This deliverable D4.1 reports on the outcomes of Task 4.1 in the MENTUPP DoA, namely Situation analysis and collection of anti-stigma best practices.

3 Approach

In WP4 task 4.1 the following tasks were carried out:

3.1 Systematic review

A systematic literature search was conducted following PRISMA guidelines for workplace interventions targeting stigmatization against mental health issues in the workplace, incorporating the findings and experiences of the European Framework for Action on Mental Health and Wellbeing and EAAD. The PubMed, Ovid Medline, PsycINFO, Scopus and Cochrane databases were searched. Initially, 1459 records were identified. We conducted abstract review of 227 articles. 109 were retained for full-text screening, and 15 met the criteria for inclusion: 6 Australian studies, 6 Canadian, 1 German, 1 British and 1 Japanese study. We have included 3 randomised controlled trials (RCTs) and 12 quasi-experimental designs. An overview of the included study characteristics is presented in Appendix 1A.

The systematic review was conducted addressing the following inclusion criteria: 1) study sample included employees or owners/managers; 2) the intervention was a training, program, workshop etc. 3) mental health outcomes were measured in terms of stigmatization against depression, anxiety, suicidal behaviour; 4) experimental or quasi-experimental design, only quantitative data 5) published in English, and 6) the intervention was delivered through the workplace. The keywords are listed in Appendix 1a, and an overview of study characteristics is provided in Appendix 1b.

3.2 Finding the key anti-stigma activists and organisations in the participating countries and collecting best practices from stakeholders and relevant best practices from WP2-3.

This task was achieved with the contribution of the other MENTUPP workpackages. WP4 collected data on the anti-stigma initiatives and organisations in the following countries: Spain, Germany, The Netherlands, Hungary, Ireland, Kosovo, Finland. Also, in the Delphi study, knowledge of anti-stigma best practices were queried from the Delphi experts, and the results collected. The initiatives and organisations were listed and information on the relevant contact persons were also collected, where available. The results were included in a table (see Appendix 2). In addition, one MENTUPP partner

(Phrenos) provided a detailed report of best practices and situation analysis in the Netherlands, it is included in Appendix 3.

3.3 Development of appropriate questionnaires for evaluating anti-stigma best practices in the participating countries.

The Delphi process is a step-by-step process by which a consensus opinion can be formed based on the opinions of a range of experts and has successfully been used to answer questions in mental health research on a wide range of topics (Jorm, 2015[1]). The initial aim of the Delphi process had been to target 3 intervention countries (Albania Hungary and Finland) involved with different SME sectors in the pilot phase (WP7). However, after discussions among the MENTUPP consortium it was agreed that it would be very beneficial if the Delphi process would target experts in all 9 intervention countries (Albania, Australia, Finland, Germany, Hungary, Ireland, Kosovo, the Netherlands, and Spain) involved in the MENTUPP Pilot (WP7) and cRCT (WP9). This should provide a robust and more detailed response to specific research questions in the Delphi study.

To streamline resources and avoid multiple demands on experts' time especially in the time of a global COVID-19 pandemic, consultation report deliverables from WP2, WP3 and WP4 were met in the same expert consultation. Thus, the MENTUPP Delphi expert consultation was designed with the aim to investigate the experiences and needs of SMEs with regards to the promotion of employee wellbeing, the prevention and management of clinical and non-clinical mental health problems, and the reduction of stigma around mental health problems in SME workplaces.

The Delphi process was the result of work by WP2, 3, 4, 5 and 8, with support from WP7 and 10, and was led by WP3 and UCC. As detailed above a shared need for information from an expert consultation was identified across WP2, 3, 4, and 5 and so to optimise resources and minimise demands on experts' time, it was agreed to merge this into one consultation process. WP2, 3, 4, and 5 all separately identified the knowledge gaps they needed to address for their area in the expert consultation, and designed questions accordingly. Weekly meetings were held throughout March, April, and May 2020 to review progress, chaired by WP3 and attended by all the involved WPs. A sub-group of WP 2, 3, and 4, with input from WP5, formulated the agreed content into a cohesive questionnaire which was piloted among members of the consortium and external experts for feedback before a final version was sent to all members of the consortium and signed off in June. The ethics application was submitted to the Social Research Ethics Committee in UCC in June and approval was received at the end of August 2020. This process was led by UCC with support from WP2 and WP3. WP8 agreed to carry out the data analysis and provided guidance on data analysis, storage, and the process for sending out the questionnaire in multiple languages. The final date for questionnaire response was 5th Oct 2020. WP3 reviewed the responses in Qualtrics and sent the data file to WP8 for analysis. All data analysis were carried out by WP8, and the results interpreted by WP 2, 3, 4, and 5.

The completed Delphi Expert Consultation report is provided in Appendix 4.

[1] Jorm, A.F., 2015. Using the Delphi expert consensus method in mental health research. Aust N Z J Psychiatry 49, 887–97. https://doi.org/10.1177/0004867415600891

3.4 Expert Meeting

The MENTUPP WP4 team together with the MENTUPP project coordinator Prof Ella Arensman met with Professor Nicola Reavley who is Principal Research Fellow at the Centre for Mental Health, Melbourne School of Population and Global Health, at the University of Melbourne, Australia, in addition to being the MENTUPP ethics advisor. Prof Reavley is an expert in the area of stigma in the workplace and anti-stigma mental health interventions and she has published widely in the area. The meeting centred on the stigma evaluation measure and the MENTUPP anti-stigma materials and previous experiences of Prof Reavley. The meeting was very informative and afterwards Prof Reavley provided further information (relevant surveys and papers by email). The minutes of this meeting are provided in Appendix 5.

4 Results

The output of the deliverable is the Situational analysis that consists of three parts: systematic review, collection of best practices and collection of expert's views through the Delphi survey:

Situational analysis

4.1 Systematic review

Overview of study characteristics

The studies include interventions with the main focus on mental health issues, especially depression and suicide. The organisations in the studies were from all areas, including public, private, for- or non-profit, manufacturing, construction, services etc. The participants in the programmes were employees and managers, in many cases a bigger proportion of male participants. The studies trialled online and/or face-to-face interventions such as training programs for managers and employees in a form of awareness training, educational workshops, supervisor trainings or online materials. Some of the studies implemented videos, digital game-based training programs and role plays in the intervention. The length of the programs varies from 30min to 2 years. Most of the studies were conducted in Australia, Canada and the UK, with 2 exceptions (1 Germany, 1 Japan). The study designs were mixed, we reviewed 3 randomised controlled trials (RCTs) and 12 quasi-experimental studies.

Study findings

The findings were mixed, ranging from significant change of attitudes towards stigma (e.g. Shann et al. 2018; Dimoff 2013), to some cases where a change in stigma attitudes occurred in both in the intervention and control group (Tynan, 2018). Sustainability of results was mixed, with sustained improvement in certain studies (Dobson, Szeto, Knaak, 2019) to no significant change when followed-up in other studies (Kubo et al, 2018). Studies demonstrated that mental health literacy was growing (Moll et al., 2018) but increasing help seeking behaviour was not shown. Considering the key role of the level of stigma in help seeking, in handling situations with employees or colleagues with mental health issues, the amount of studies aiming to change the attitudes toward these problems is relatively low. It is a significant aim of WP4 within MENTUPP to find the best ways to tackle the negative view

towards depression and other mood disorders (personal and perceived, too), in order to increase the well-being of the population as well as the productivity of SMEs.

See detailed findings in Appendix 1c.

4.2 Key anti-stigma organizations and best practices

The collected anti-stigma organizations and best practices are listed in Appendix 2 along with the detailed report of best practices and situation analysis in the Netherlands (Appendix 3).

In Appendix 2 information is presented on best practices collected from Spain (6), Germany (14), The Netherlands (5), Hungary (19), Ireland (1), Kosovo (4), Finland (5). The initiatives range from open air events (The Social Run) to special programmes for affected people (Lélekben Otthon Alapítvány, Services for family members). The Anti-Stigma activities were rarely the main aim of the best practice (e.g. Anti-Stigma-Kampagne Mecklenburg-Vorpommern), but in a few cases this was defined as an aim of the initiative (e.g. E-Learning psychological diversity on the workplace).

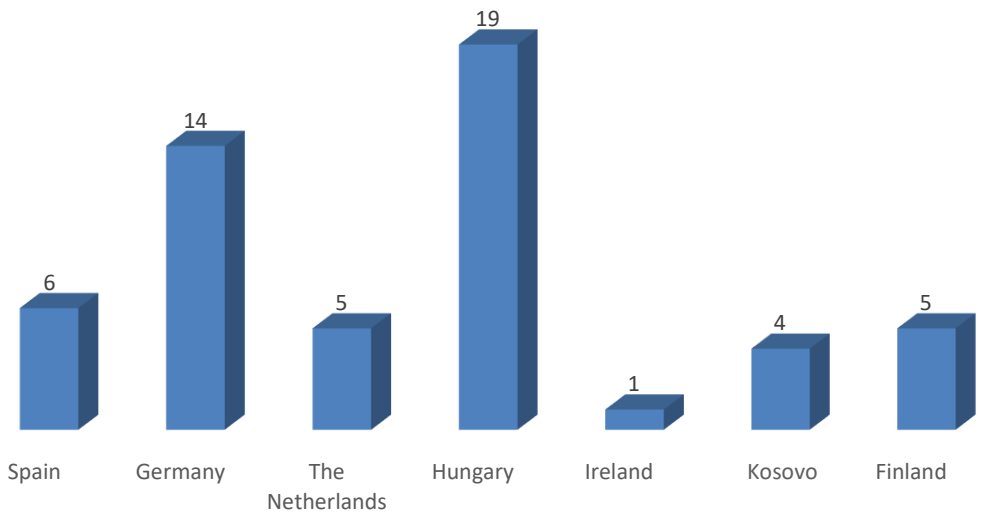

Figure 1: Number of best practices collected per country

The best practices from Germany, The Netherlands, Ireland and partly from Spain are special programmes, interventions and other activities aiming to reduce stigma or promote information about mental health, whereas in other countries there were no concrete activities but organisations, aiming to achieve stigma reduction.

In Germany the relevant organisations are mainly fighting depression. Their aim is to decrease the proportion of undiagnosed mental health disorders through help, information (online and printed, activities for the affected and for the public) and decrease the level of stigmatization.

In Hungary, we collected information on organisations fighting against stigma and discrimination in a broader sense as the anti-stigma activities were similar in each field. Some organisations were offering legal aid for health patients, not only for mental health, but also clients with any health problems and

issues.

The collection of Kosovo initiatives consists of organisations aiming to address the rights of patients. The anti-stigma activities were achieved through the activities of communities and the health care service.

The Finnish organisations' aim is to promote mental health and help the affected people as well as family members. The Finnish Central Association of Families of People with mental illness is the central organisation for local families, and a national lobby organisation for the families of people recovering from mental illness. The purpose of FinFami is to support local member associations and provide them with services to help the families of people with a mental illness.

Overall, an analysis of best practices in the Netherlands (Appendix 3) found 5 best practices. Those practices involve different types. There was one public event, The Social Run (https://www.socialrun.nl/), which is an international activity. In the Netherlands, this activity is advertised for companies through consultations, so it becomes a team run with the whole organisation focused on equality and openness on the job. There are trainings focusing on organizations like "The Talk", which is an in-company training for employers focusing on improvement of identification of mental health problems and talking openly about these problems with employees. There are two online tools aiming to tackle stigmatisation at the workplace, such as E-Learning psychological diversity on the workplace and CORAL. The fifth initiative, Photovoice is an expressive method helping people and their environment with raising awareness about their personal and social roles, through photography.

The experts in the Delphi report mentioned the initiatives known by them, also listed in the collection – the difference between the existing initiatives and the ones mentioned by the Delphi experts demonstrates the lack of information and dissemination in the area of stigma interventions.

The collection of best practices reveals the need for anti-stigma programmes tackling the lack of knowledge and misconceptions about people living with mental health issues. Even in those areas and sectors where more initiatives exist it is important to disseminate the existence and utility of such programs among the members of the target groups.

See the list of collected best practices in Appendix 2.

4.3 Delphi report

WP4's input into the Delphi survey concentrated on the level of stigma and existing anti-stigma activities and tools present in the workplace. In order to analyse the current situation, the Delphi questionnaire assessed by the MENTUPP project included questions regarding stigma directly and indirectly.

(MHI is the abbreviation for Mental Health Issues.)

Questions regarding stigma indirectly

There are several barriers when implementing methods, policies, or interventions at promoting employee mental health, some of them affect stigma. 11 experts reported the stigma itself, the same number reported fear of possible negative effects on career or fear to open up about mental health, due to fear of prejudice by others. Self-stigmatisation as a barrier was mentioned by two experts.

As a key facilitator, 13 experts reported the need for openness in conversations about MHI in order to reduce stigma.

For the SME sector one of the main arguments is the consequences on business outcomes, where only 4 experts see stigma as a negative factor. This shows the importance of providing information to SME's about the connection between productivity and MHI.

Regarding the available tools and information, most experts report only very few or no material about MHI for employees. However, between 60 - 70 % agree that those tools would be useful, of which materials providing information about depression or anxiety and how to cope are the most important. This information would be important for all groups, the employees, supervisors and the managers.

Questions regarding stigma directly (Delphi section about anti-stigma activities)

Communication about MHI is a key in attitudes regarding stigma. Most experts disagreed that there is open communication, nevertheless the answers were somewhat mixed and thus most employees choose to hide their MHI (Figure 2).

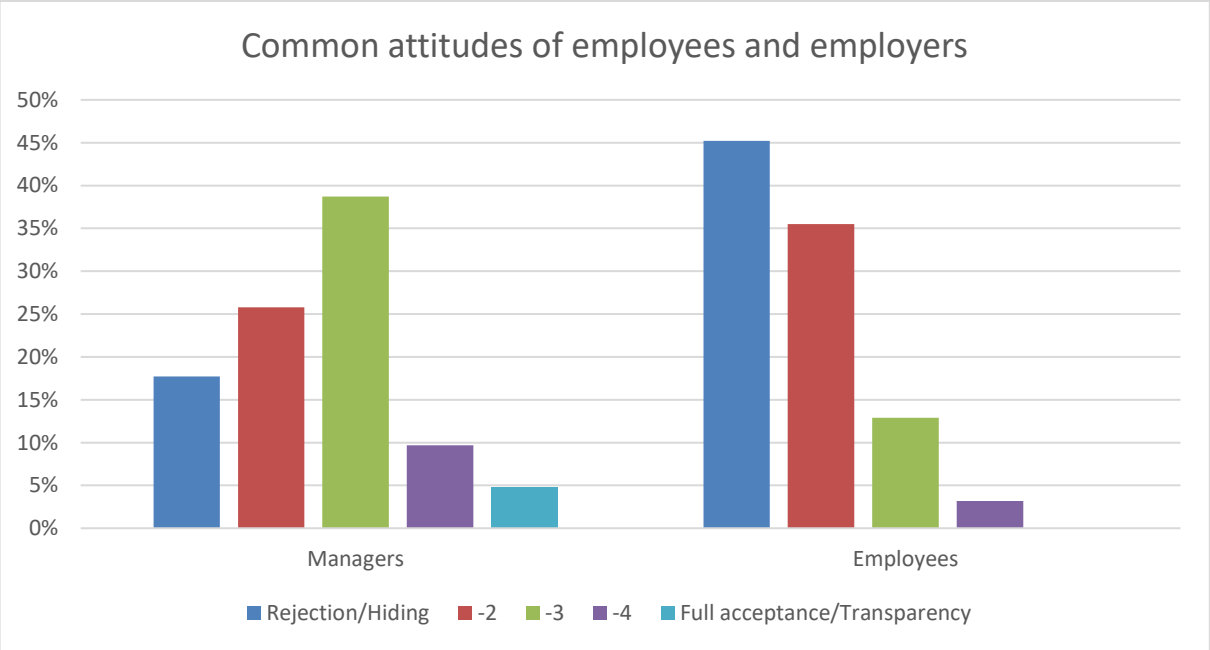

Figure 2: Common attitudes towards openly expressing mental health issues of employees and employers

A strategic and coordinated approach to reduce stigma related to mental health problems rarely exists, only 27.4% of the experts answered that there is limited effort to reduce stigma in the workplace. The experts' answers to the query if employees can speak openly about their MHI was mostly mixed, as 26 experts agreed, 9 experts disagreed and 24 experts chose a neutral answer.

Workplaces do seem to take steps to avoid stigma and discrimination, according to 62.8% of the experts (but only to a small extent according to 46.8%, and not at all according to 16% respectively).

Only 9.7% of experts stated that there are major steps taken against stigma and discrimination in the workplace. Policies regarding MHI, including rights and discrimination somewhat exist, only around 10% of experts reported that these policies were present to a large extent.

There are several risks that employees with MHI must face as identified by the Delphi experts. The most common risks are (the number of experts making this comment are in brackets):

- Job loss through dismissal (16)
- Stigmatization (16)
- Being rejected by colleagues or subgroups in the workplace (13)
- Discrimination in general (i.e., being treated differently because of mental health problems) (10)
- Getting unsupportive responses that may increase mental health problems (e.g., not be taken seriously, minimalization, inappropriate advice, misunderstanding) (8)
- Becoming less valuable in the organization's point of view (5)
- Negative influence on later career path (4)
- Bullying (2)
- Colleagues and managers might experience mental health problems as too much to handle (1)
- Being personally exposed (1)

Nevertheless, in some cases employees with MHI can have benefits, too, as identified by the Delphi experts.

- Getting support from colleagues or managers in the workplace (16)
- Colleagues and managers will be more understanding (11)
- Facilitating help and/or receiving suggestions for help seeking (9)
- Creating a possibility to adjust working conditions according to the employee's needs (9)
- De-stigmatisation of mental health issues in the workplace (8)
- Addressing the problem and facilitating a solution (7)
- Sense of relief for the employee expressing mental health problems (6)
- Getting treatment faster (5)
- Manager is stimulated to make decisions (3)
- Creating an open work context (2)
- Better work life balance (1)

Necessary activities to reduce stigma

The Delphi experts could choose which activities they value the most useful in order to reduce stigma. Counselling, awareness campaigns and workshops received most weight, more than 50% of the experts perceived them useful to a large extent. Printed materials and interactive options (email or chat) are valued somewhat less important, but still most of the experts would recommend them in stigma reduction. A website about how to reduce stigma in the workplace was also positively ranked by the Delphi experts (35% to a large extent and 19% somewhat). Online information materials about mental health were also ranked positively (37% to a large extent and 27% somewhat).

Acceptability of anti-stigma interventions

In case of any interventions, acceptability is a key factor. Almost all the experts view those programmes as acceptable but to varying degrees, (approx. one third of the experts agreed to a large extent, a further 34-40% somewhat agreed with the query statements, Figure 3).

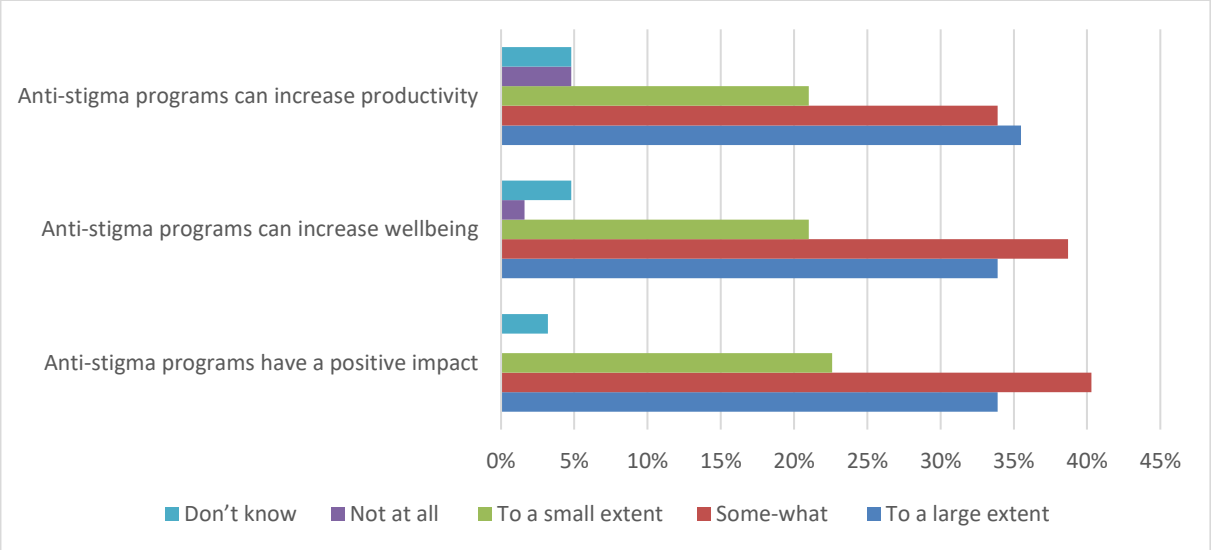

Figure 3: Degree to which managers would agree with statements about anti-stigma programmes (%)

The main barriers according to the Delphi experts when conducting mental health anti-stigma activities are mainly due to lack of knowledge and information, shortage of time and funding. The results indicate that if the key role of MHI is emphasised, the acceptance of such programmes would grow (Figure 4). A significant result from the Delphi survey is that the participation in mental health interventions is hampered by the stigma and fear of discrimination itself. This supports the argument that anti-stigma activities would accelerate the participation and also would decrease stigma, and the process would enhance itself.

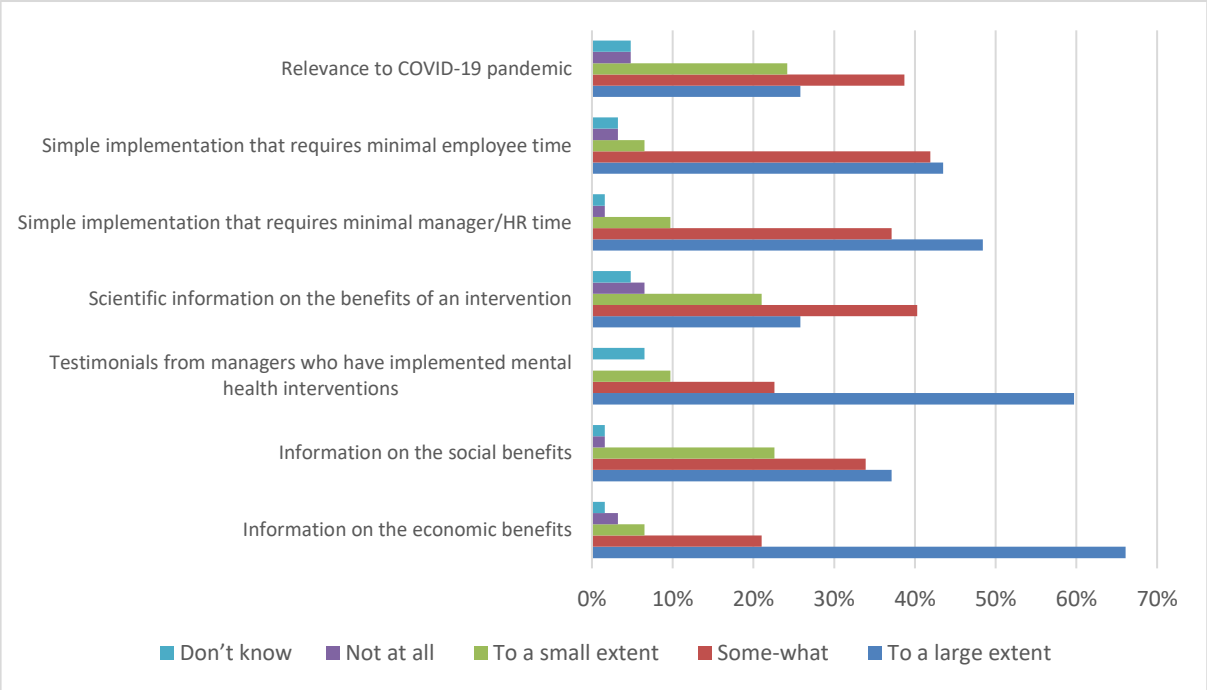

Figure 4: The considerations which may influence managers in deciding whether or not to implement interventions in the workplace

According to the Delphi report, concerns about implementing mental health interventions exist. Experts advised that they had concerns regarding implementation of mental health programmes as outlined below:

- that the workplace is not responsible for employees' mental health (75.8%)
- staff will hesitate to participate in workplace-based interventions (82.2%)
- that there is a lack of resources for implementation (87.1%)
- that employees may access interventions during worktime or using work resources (82.2%)
- that the workplace is not an appropriate setting for MHI interventions (82.2%)

Experts listed some anti-stigma programmes that they were informed about (see in Appendix 2). The answers show the lack of such programmes in some areas in Europe, especially in Central-Europe.

Summary

Although our results demonstrate that there are many unmet needs considering the implementation of workplace-based anti-stigma and anti-discrimination programmes and the relevance of developing the MENTUPP interventions, the results also demonstrated that important challenges remain in terms of implementation.

Needs and attitudes toward workplace-based anti-stigma programmes

Most importantly, the experts agreed with various well-defined needs and strategies to fulfil them. Most of the experts reported that there are few or no actions considering stigma in the workplaces,

although there are some good practices about sharing information about MHI, protecting the rights of employees with MHI and in some workplaces, some policy steps against stigma and discrimination have already taken place. Accordingly, the most common attitude of employees with MHI is to hide them, and the most common underlying reason for hiding any MHI is the fear of job loss, stigmatisation, rejection by colleagues and discrimination in general.

On the other hand, the experts reported many possible benefits of workplace-based anti-stigma interventions (increased support and understanding, facilitating problem solving and help seeking and creating flexible workplace conditions adjusting the employee's needs). Although it was reported that managers have a mixed but rather positive perception toward the results of workplace based anti-stigma actions (generally positive impact, increased wellbeing and increased productivity), a lot of possible concerns were also reported about the concrete steps of implementation (lack of resources, hesitation of employees, workplace is not an appropriate setting).

Interventions

Currently, there is a lack of evidence-based anti-stigma activities, especially in Central-Europe. The experts support the significance of in person interventions (counselling, workshops given by expert-through-experience, workshops given by a professional) and the significance of awareness campaigns. However, due to the COVID-19 Pandemic, the role of online interventions and tools is now becoming increasingly important. These tools are also positively ranked by the experts, however less than the in-person solutions. The current pandemic situation supports the tools planned and being produced for the Anti-Stig Harbour in Task 4.2 and 4.3 (animation videos for the different sectors, information material online and downloadable and printable format, questionnaires for measuring the stigmatisation) and these tools were also positively rated by the Delphi experts.

For the complete Delphi Expert Consultation Report, see Appendix 4.

5 Impact & Conclusion

This deliverable D4.1 addresses 2 key aims of MENTUPP WP4:

- To systematically review evidence-based interventions for the reduction of stigma associated with depression, anxiety and suicidal behaviour in the workplace.
- To conduct a situation analysis and consultations with experts and relevant stakeholders in construction, health, and ICT SMEs on stigma of mental health in the workplace with a specific focus on gender differences and incorporate the relevant findings of WP2 and WP3.

The aim of the Situational analysis (D4.1) is to support the planned activities and their contents being developed in WP4 as part of the MENTUPP project. The existence of stigma related to mental health issues and also the need to improve the help seeking behaviour and level of knowledge of workers in the SME sectors is well known, but the result of the MENTUPP project depends on identifying the concrete needs and possibilities of the target group, namely SME's. The parts of the Situational analysis were carried out in order to fine-tune the contents and tools of MENTUPP Component C, with special emphasis on the COVID-19 pandemic that occurred after the project started.

Overall, we found that several initiatives exist, however significantly different situations were reported in the countries targeted by the project. Australia, Canada, and the UK have conducted the most number of studies regarding stigma in the workplace, and the Western-European countries have more activities in order to reduce stigma related to mental health problems. Nevertheless, even in the countries that have more programmes, the information about those programmes are not highlighted to SME's, underlining a lack of dissemination of the anti-stigma activities. The experts understand and accept the importance of the aim of anti-stigma activities, however they have doubts about the use of the different tools, and they identify several possible obstacles, mainly based on attitudes.

Based on the findings of the Situational analysis the messages and tools for the SMEs can be finalised, even with slight differences in the different work sectors considering the different levels of mental health literacy and existing initiatives. The experts believe that the offline solutions and in person delivery can be slightly more useful, however due to the COVID-19 pandemic, the online tools will gain greater acceptance. We also should put emphasis on the sustainability of the results. The main focus in the process of implementing the results of the Situational analysis is to address the special needs of the SME sector, to develop interventions that reduce the stigma of depression, comorbidities and suicidal behaviour in the workplace, for the purpose of MENTUPP component C: destigmatisation of mental health in the SMEs' workplace.

This deliverable D4.1 addresses of Task 4.1 in the MENTUPP DoA, namely *Situation analysis and collection of anti-stigma best practices.* The results of this deliverable facilitate Task 4.2 *Development of new anti-stigma e-mental health tools and a multi-faceted anti-stigma programme as part of the MENTUPP intervention*.

6 Appendices

Appendix 1a Systematic review, process

Appendix 1b Study characteristics and list of studies included

Appendix 1c Study findings

Appendix 2 Anti-stigma organizations and initiatives

Appendix 3 Situation analysis and Anti Stigma best practices in the Netherlands - Phrenos report

Appendix 4 Delphi Expert Consultation report (overall report of the Delphi study carried out across WPs 2, 3 and 4 in MENTUPP)

Appendix 5 Expert meeting # 1 with Nicola Reavley, meeting minutes.

Appendix 1a

Keywords of the Systematic review

- depress* OR suic* OR anx* OR self-harm OR "mental health" OR discrimination OR exclusion
- AND
- occupation* or workplace or SME OR job OR "small-sized enterprise*" OR "medium-sized enterprise*" OR "small enterprise*" OR "medium enterprise*" OR "small-sized compan*" OR "medium-sized compan*" OR "small compan*" OR "medium compan*" OR "small-sized business*" OR "medium-sized business*" OR "small business*" OR "medium business*" OR "small-sized organization*" OR "small-sized organisation*" OR "medium-sized organization*" OR "medium-sized organisation*" OR "small organization*" OR "small organisation*" OR "medium organization*" OR "medium organisation*")
- AND
- anti-stigma OR stigma
- AND
- reduced OR promot* OR program* OR campaign OR improve* OR intervention OR educat* OR seminar* OR workshop* OR course

Initially 1459 records have been identified.

1. kör	**1. round**	**2. round**	**3. round (AR)**	**Full text review**
Ovid	586	241	87	46
Scopus	591	405	86	43
Cochrane	58	88	54	20
Pubmed	224			
All:	1459	734	227	109

Third round – abstract review		**aprropriate**	**excluded**	
	All		off topic	no intervention
For full text review	227	109	68	51

Appendix 1b

Overview of study characteristics and studies included

Overview of study characteristics

First author/ year	Study Design	Population No. started (No. completers)	Gender at baseline	Sector	Intervention	Intervention Intensity	Country
Shann et al 2018.	Randomized controll trial	196 leaders	95 male 101 female	public 32% private 53% not for profit 15% other 1%	Beyondblue online material: Main focus on depression: -information to read, -video clips of organizational leaders speaking about mental health in the workplace (including their own experiences), -interactive exercises in which participants could calculate the cost of untreated depression in their workplace and the specific risk factors that exist in their organization.	30 – 45 min for leaders	Australia

Kristman 2019	quasi experimental	89 pre 61 post interventions	44 male 15 female	non specific 319 randomly selected companies mainly white collar 1. Mining, etc.; 2. Manufacturing 3. Trade, Transportation 4. Information and cultural industries; Finance/insurance; RealEstate, etc. 5. Professional, scientific 6. Educational 7. Arts, entertainment, 8. Health care and social assistance 9. Other services 10. Public administration	multi-faceted 1. six session Standard to Action training program designed to help employers implement the Standard in their workplaces; 2. education workplace MH various experts to discuss topics related to workplace mental health; 3. a social marketing campaign including a photovoice exhibit that was developed from photos and captions submitted by community members	2 yrs	Canada
Dimoff 2013	controlled study active vs wait list	350 leaders/ managers		large companies, non specific	mental health awareness training	3 hrs	Canada

Blignault 2010		263/236c completed	102/134 M/F	Macedonian community mainly physical workers	education through play performance	one play	Australia (Macedonian community)
Hamann et al., 2016	Longitudinal cohort study	580 managers	210 women 370 men	leaders (445; 77%), members of the workers' council (35; 6%), workers in human resource department (60; 10%).	“Mental-health-at-the-workplace” educational workshop	1-1,5 days training	Germany
Hanisch et al., 2017	Longitudinal cohort study	48 (47 managers)	92% male, 8% female	global enterprise	Leadership Training in Mental Health Promotion (LMHP), a digital game-based training program for leaders which is combining games and simulations in a virtual environment., The player was put into the position of a manager. During that time period, it was the manager’s task to supervise a virtual team and manage employee mental health effectively.	one single session, 1.5- 2 hours long over a virtual time period of 7 weeks	UK

King et al., 2018	Longitudinal cohort study	30052/ (20125)	male 92,1% female 7,9%	Technicians and Tradeworkers 40.2% Labourers 24.7% Managers 16.7% Machinery Operators and drivers 13.9% Clerical and Administrative Workers 2.7% Professionals 1.8%	General Awareness Training (GAT) alone or part of the Life Skills Toolbox	1 hour training session	Australia
Kubo et al. 2018	Single arm pilot trial	91 (83) employees	male: 77% female: 23%	manufacturing company	Mental Health First Aid (MHFA) training program modified for workplace settings.	2 hour training course	Japan
Ross et al. 2019	mixed-methods study	104 volunteers	male: 100%	construction industry	Mates in Construction (MATES) program connector training- the training includes Livingworks safeTALK	four-hour onsite training session	Australia
Szeto et al 2019	non-randomized quasi-experimental pre-post follow-up design	5598 (4649) Frontline staff 75.8% (3,449) Supervisory staff 26.4% (1,210)	male 65.2% female 33.2%	Corrections 9.0% (418) Emergency Services (9-1-1) 3.9% (192) Fire Services 17.7% (821)	Road to Mental Readiness for First Responders program (R2MR) The program contains 3 main components: stigma reduction through video contact-based education, the Mental Health Continuum Model, and the	4-h or 8h program	Canada

				Police Services 56.5% (2,623) Paramedics 13.0% (605)	"Big 4" coping and resilience skills.		
Griffith et al 2016	Randomised controlled trial	507 employees	MH-guru: male: 29%, female: 70%; **controls**: male: 23.4% female: 76.6	multi-departmental government workplace	1. online depression and anxiety educational workplace induction program (Mental Health Guru; MH-Guru). MH-Guru comprises two modules, the first focused on depression and the second on General anxiety disorder 2. wait list control	2-week online depression and anxiety educational program (1 module/week, 30min/module)	Australia
Tynan et al. 2018	Non-Randomised controlled trial	1275 mines (1163) 117 supervisors (114)	MATES in mining: 1014 male; 135 female; 14 not specified Supervisor training: 92 male; 10 female; 12 not specified.	Manager Professional Trades worker Machinery operator Admin or other	MATES in mining peer-based, multi-component mental health and suicide prevention program and supervisor training	one hour 'general awareness training' (GAT), additional four hours of 'gate- keeper training', Key workers on site are also provided a two-day 'applied	Australia

						suicide intervention skills training' (ASIST).	
Sandra E. Moll et al. 2018	randomised, parallel-group	two Ontario hospitals employees 192: 97 Beyond Silence 95 MHFA	female (88.5%)	healthcare employees full-time employees (74.5%) engaged in clinical roles (59.4%)	Participants were randomly assigned to 1 of 2 group-based education programs: Beyond Silence (Beyond Silence program includes a contact-based educational approach) Mental Health First Aid	comprising 6 in-person, 2-h sessions plus 5 online sessions co-led by employees who personally experienced mental health issues a standardised 2-day training program led by a trained facilitator	Canada

Sandra E. Moll, Jessica VandenBussche 2018	randomized parallel-group trial	182 hospital employees subgroup of 18 participants were also recruited to participate in in-depth individual interviews about their experienc	Mental Health First Aid: male 1 female 8 Beyond Silence male 1 female 8	clinical and nonclinical positions, managers front-line workers	Beyond Silence Customized for health care workers Scenarios, videos, role-play, online discussion 35% mental health literacy, 35% stigma- reduction contact- based education, 30% skill development Mental Health First Aid Designed for the general public Standardized, module based Focused on recognizing the signs and symptoms of mental health problems, providing initial help and guiding a person toward appropriate professional help	12 hours: six 2-hour sessions and 5 online sessions 12 hours over 2 full days	Canada
Dobson KS.; Szeto A.; Knaak S. 2019	open trial methodology	1292 participants across the 8 replications and a total of 1155 of completed and matched pre- and postsurveys	male 419 female 719	Canadian jurisdictions	trained facilitators, work- shop manuals, contact-based videos that present actual employees and managers dealing with issues related to the program's content, discussion exercises, and personal goal setting to begin to enact the coping skills within the program "train-the- trainer" model if an employer prefers, trained group facilitators can be sent to directly deliver The Working Mind program	frontline workers 4-hour group program managers 8-hour program	Canada

Included studies of WP4 systematic review

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13. Shann, C., Martin, A., Chester, A., & Ruddock, S. (2019). Effectiveness and application of an online leadership intervention to promote mental health and reduce depression-related stigma in organizations. *Journal of occupational health psychology*, *24*(1), 20.

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Appendix 1c

Systematic review findings

Results from Randomized Controlled Trials				
First author/year	Outcome measure	Evaluation timepoints	Main findings	QATQS score
Shann et al. 2018.	Managerial Stigma Toward Employee Depression Scale - Affective Stigma Subscale, - Behavioral Stigma Subscale, an - Cognitive Stigma Subscale	pre – post follow up	After controlling for preintervention variance, one- way multivariate analysis of covariance using Pillai's trace showed a statistically significant difference in survey stigma between experimental and control groups, V =.09, F(3, 189)= 6.26, p <.001, Follow-up univariate analyses of variance were conducted on the outcome measures and showed that at posttest, affective stigma was significantly different between groups, F(1, 191) 14.55, p .001, 2 .07; estimated marginal means indicated that the experimental group had lower affective stigma scores (M 9.42, SEM .24) at postsurvey compared with the control group (M 10.51, SEM .16).	
Dimoff 2013	Mental Health Knowledge Schedule	2 weeks before (baseline)	Significant improvements in knowledge were observed for the intervention group from T1 (M = 3.88, SD = 0.41) to T2	

	(MAKS; Evans-Lacko et al., 2010). Personal Depression Stigma Scale 9-item General Self-Efficacy Scale	24 hrs after 8 weeks post training	(M = 4.31, SD = 0.43; t (87) = -7.92, p < .001), and from T1 to T3 (M = 4.32, SD = 0.40; t (87) = -8.62, p < .001), but not between T2 and T3. Significant improvements in attitudes were also observed for the intervention group from T1 (M = 2.98, SD = 0.39) to T2 (M =3.25, SD = 0.37; t (87) = -5.60, p < .001) and from T1 to T3 (M = 3.20, SD = 0.42; MENTAL HEALTH AWARENESS TRAINING FOR LEADERS t (87) = -4.06, p < .001). No significant improvements in attitude were observed for the intervention group between T2 and T3. Significant improvements in self-efficacy were also observed for the intervention group between T1 (M = 4.17, SD = 0.66) and T2 (M = 4.98, SD = 0.57; t (87) = -9.94, p <.001), and between T1 and T3 (M = 4.94, SD = 0.53; t (87) = -9.66, p < .001), but not between T2 and T3. Significant improvements in promotion intentions were also observed for the intervention group between T1 (M = 4.50, SD = 0.66) and T2 (M = 5.24, SD = 0.51; t (87) = -9.76, p < .001) and between T1 and T3 (M = 5.14, SD = 0.62; t (87) =-7.88, p < .001).	
Griffith et al. 2016	personal stigma about depression and anxiety (DSS-personal) (GASS-personal), depression and anxiety literacy	online surveys at baseline, 1 week post-intervention and at 6-month follow-up	MH-Guru group showed significantly greater ↓in depression and anxiety personal stigma. Between group effect sizes in stigma for depression were − 0.56 and − 0.47 at post-test and 6-months respectively and − 0.42 at both time points for anxiety (p<.001) DSS (Mean, SD) MH-Guru: before: 7.1 (4.9) after: 3.9 (3.8) follow up 4.2 (3.8)	Moderate

	help seeking intentions for anxiety and depression		Control: Before: 7.3 (5.2) after: 6.8 (5.0) follow up: 6.6 (5.2) F (2, 294.1)=2.5 *P*<.001 GASS (mean, SD) MH-guru: before: 5.1 (5.1) after: 2.5 (3.9) follow up: 5.1 (0.48) control: before: 4.9 (5.6) after: 5.0 (5.3) follow up: 4.9 (0.34) F (2, 286.1)=19.8 p <.001	
Results from quasi-experimental studies				
Hamann et al., 2016	Stigma against depression (DSS)	Pre, post training	significant ↓in personal stigma (mean [SD], 15.5 [3.8]; paired t-test: t = 27.6, p < 0.001)	
Hanisch et al, 2017	Knowledge about mental health (MAKS) stigma towards mental health problems (OMS-WA) New General Self-Efficacy Scale	pre, post-training, 3-month follow-up	↑ managers' knowledge about mental health and mental illness (*P*<.001), postitive changes on attitudes toward people with mental health problems (*P*<.01), ↑ self-efficacy to deal with mental health situations at work (*P*<.001)	
King et al 2018.	Self-reported Suicide and Suicide Prevention Awareness and Beliefs	pre and post training	Significant ↑ in agreement with following beliefs: People considering suicide often send out warning signs or invitations (β= −0.429, p<0.001) Poor mental health is a workplace health and safety issue	

			(β=−0.155, p<0.001); The construction industry must do something to reduce suicide rates (β=−0.151, p<0.001). No change in agreement with Talking About Suicide Can Cause Suicide (p=0.473)	
Kubo et al. 2018	Stigma towards mental health problems - Link's Devaluation-Discrimination Scale	pre-program, post-program, 1 month follow up	↓ after the program (before: 28.29, after: 26.11 p=0.003), no difference 1 month after the program.	
Ross et al. 2019	suicide awareness and knowledge, attitudes to help-seeking and help giving; emotional well-being focus group qualitative analysis	pre-program, post program	Stigma reduction in content analysis	
Szeto et al. 2019	stigma towards mental health problems (OMS-WA) Resiliency skills scale: Q1: I understand how mental health	pre-program, post-program, 3 month follow up	↓in stigma were observed for the total scale and all subscales. before: 1.97 (SD: 0.47). After: 1.85 (SD: 0.49) coeff: 0.123 SE: 0.008 z: 15.87 p<0.001 Reductions in stigma were maintained until the final follow-up for the total scale. coeff: - 0.002 SE: 0.012 z: - 0.13 p=0.899 ↑ Resiliency Scale: before: 3.65 (SD: 0.64) after: 3.84 (SD: 0.60), representing an overall mean improvement of 0.19 scale points.	

	problems present in the workplace Q2: I plan to seek help for my mental health problems, when needed Q3: When I am concerned, I ask my colleagues how they are doing Q4: I talk about mental health issues as freely as physical health issues		(coeff: - 0.190 SE: 0.015 z: - 12.90 p<0.001)	
Tynan, 2018	mental health stigma, help-seeking behaviour, perception of the workplace commitment to mental health	pre-test/post-test 10 months follow up	The findings indicate a trend towards a decrease in stigma across both control and WWMHP sites, however the effect of time or treatment was not significant (p > 0.01)	
Kristman 2019	Four questions assessed familiarity and level of commitment to implementing the Standard in the workplace. Eight questions addressed	baseline after 2 yrs of continuous multi-faceted intervention	significant difference in perceived mental health stigma between intervention and non-intervention group (Mean intervention group: 1.52 vs. non-intervention group: 2.00 MD: -0.48)	

	level of knowledge related to mental health and were measured on a five-point scale			
Blignaud 2010	structured interview open ended questions	after intervention 2003 and 2009 follow up	Responses obtained at Phase 1 (2003) and after Phase 3 (2009) to the question: If a person you knew was showing signs of mental illness who would you contact for help? Responses 2009 2003 (n = 234) (n = 99) Health worker/service 197 (84%) 60 (60%) Family 82 (35%) 46 (46%) Person him/herself 25 (11%) 10 (10%) Friends 15 (6%) 3 (3%) Other 9 (4%) 4 (4%) No-one 5 (2%) 5 (5%) Unsure 1 (–%) 3 (3%) Depends 0 (–%) 3 (3%)	

Table 3: Responses obtained at Phase 1 (2003) and after Phase 3 (2009) to the question: If a person had a mental illness do you think that other people's attitudes toward them would change in anyway? How might they change?

Attitudes	2009			2003		
	Experienced (n = 76)	Other (n = 159)	Total (n =235)	Clients & carers (n = 46)	Community members (n = 53)	Total (n = 99)
Positive	36 (47%)	94 (59%)	130 (55%)	1 (2%)	6 (11%)	7 (7%)
Negative or other[a]	40 (53%)	65 (41%)	105 (45%)	45 (98%)	47 (89%)	92 (93%)
Total	76 (100%)	159 (100%)	235(100%)	46 (100%)	53 (100%)	99 (100%)

Note: a) Includes qualified and uncertain responses and 'hope' that others would respond positively.

Table 4: Responses obtained at Phase 1 (2003) and after Phase 3 (2009) to the question: If a person had a mental illness do you think their family should share this information with their extended family and friends?

Disclose	2009			2003		
	Experienced (n = 76)	Other (n = 158)	Total (n =234)	Clients & carers (n = 46)	Community members (n = 53)	Total (n = 99)
Yes	65 (86%)	144 (91%)	209 (89%)	20 (43%)	43 (81%)	63 (64%)
No	11 (14%)	14 (9%)	25 (11%)	26 (57%)	10 (19%)	36 (36%)
Total	76 (100%)	158 (100%)	234 (100%)	46 (100%)	53 (100%)	99 (100%)

Sandra E. Moll et al. 2018	3) mental health literacy 4) stigma towards co-workers with mental illness (based on the 15-item Opening Minds Scale for Health Care providers); 5) help-seeking behaviour (including the standardised Attitudes Towards Seeking Professional Psychological Help scale[21]); 6) help-outreach behaviour (total number of behaviours based on a pre- identified list) post-group and follow-up surveys included open-ended questions asking for feedback on the programs	3-mo assessment, 6-mo follow-up Online surveys were completed by participants at 3-mo intervals: at baseline, immediately following program completion (at 3 mo), and 3 mo following program completion (at 6-mo)	Neither program led to significant increases in help-seeking or help-outreach behaviours. Both programs increased mental health literacy, improved attitudes towards seeking treatment, and decreased stigmatized beliefs, with sustained changes in stigmatized beliefs more prominent in the Beyond Silence group.	

Sandra E. Moll, Jessica VandenBussche 2018	in-depth semistructured interviews explored the participants perceptions of the program,	postgroup and/or 3-month follow-up surveys subgroup of 18 in-depth individual interviews about their experience	Based on the study findings, 5 key design principles appeared to shape the perceived impact of the programs: (1) contact- based education, (2) contextually relevant information, (3) an opportunity to explore varied perspectives, (4) sufficient time to integrate and apply learning, and (5) organizational readiness/support.	
Dobson KS.; Szeto A.; Knaak S. 2019	Stigma was measured using the Opening Minds Scale for Workplace Atti- tudes[16] (OMS-WA) improvement in resiliency skills was assessed with a 5-item scale that was developed for the evaluations.	outcomes were assessed before the program, immediately at its conclusion, and at a 3-month follow-up period	The results of the mixed-model analysis for the pre- to postchange on the OMS-WA revealed statistically significant reductions in stigma for the total scale, coefficient 1⁄4 .167, SE 1⁄4 .08, z 1⁄4 20.72, $P < 0.001$, and all subscales (all Ps < 0.001). The mixed-model analysis for the pre- to post- change on the resiliency skills scale revealed statistically significant improvement at the 95% level of confidence ($P < 0.001$).	

Key. DSS: Depression Stigma Scale. MAKS: Mental Health Knowledge Schedule, OMS-WA: Opening Minds Scale for Workplace Attitudes, GASS: *The Generalised Anxiety Stigma scale*

Appendix 2.

Anti-stigma organizations and initiatives

Country	Web	Owner/Founder
Spain		
"1 de cada 4" (*1 out of 4*)	https://www.1decada4.es/	
"La integración siempre es la mejor respuesta" (*Integration is always the best answer)*	https://www.mscbs.gob.es/campannas/campanas17/saludMental.htm	
"Salud mental y mujer: empoderar a las mujeres con enfermedad mental" (*Mental health and women: empowering women with mental illnesses)*	https://consaludmental.org/centro-documentacion/salud-mental-mujer-empoderar-mujer-enfermedad-mental/	
"#NoTeHagasElLoco" *(#Don'tActAsAFool)*	https://www.mediaset.es/12meses/campanas/notehagaselloco/	
"La primera etiqueta" *(The first label)*	https://www.youtube.com/watch?v=rWKLKR5VDuM&feature=youtu.be	
"Obertament" *(Openly)*	https://obertament.org/es	
Germany		
Wo ist die Grenze?	https://www.bezirkskliniken-mfr.de/ueber-uns/kampagne-wo-ist-die-grenze/	Bezirkskliniken Mittelfranken
Anti-Stigma-Kampagne Mecklenburg-Vorpommern	http://antistigma-mv.de/	Landesverband Sozialpsychiatrie MV e.V., Aktion Mensch
Bierdeckel gegen Vorurteile	https://www.ptv-sachsen.de/angebote-leistungen/beratung/gemeinsam-mehr-erleben-netzwerke-verbinden-foerderprojekt/	Psychosoziale Trägerverein Sachsen
Blaupause – eine Initiative für mentale Gesundheit im Gesundheitswesen	https://blaupause-gesundheit.de/	Blaupause - Initiative für mentale Gesundheit im Gesundheitswesen e.V.
Akzeptanz für Psychische Gesundheit	https://www.depressionsliga.de/	Deutsche DepressionsLiga; Aktionsbündnis Seelische Gesundheit
Es ist normal verschieden zu sein	https://www.apk-muenster.de/	Vereins der Angehörigen psychisch Kranker Münster e.V.

In Würde zu sich stehen	https://www.eckhard-busch-stiftung.de/	Eckhard Busch Stiftung
Wanderausstellung "Wege aus der Depression"	https://www.deutsche-depressionshilfe.de/start	Stiftung Deutsche Depressionshilfe
Fields for hope	https://www.deutsche-depressionshilfe.de/start	Stiftung Deutsche Depressionshilfe
MUT-Tour	https://www.depressionsliga.de/	Deutsche DepressionsLiga
Die Wunschperle. Vom Einfluss seelischer Erkrankungen auf Geschwisterkinder	https://www.bapk.de/projekte/die-wunschperle-geschwisterbuch.html	BApK
Selbst Betroffene Profis	https://dgbs.de/bipolare-stoerung/fuer-betroffene-profis/selbst-betroffene-profis	DGBS Referat "Selbst Betroffene Profis"
#BreakingTheSilence - Programm zur Destigmatisierung psychischer Erkrankungen am Arbeitsplatz	https://new.siemens.com/global/de/unternehmen/nachhaltigkeit/gesundheit/psychischegesundheit.html	Siemens
Wanderausstellung „GRENZen erLEBEN“	https://www.caritas-nah-am-naechsten.de/sozialpsychiatrischer-dienst-traunstein/grenzen-erleben	Caritas
The Netherlands		
E-Learning psychological diversity on the workplace	https://e-learning.psychischediversiteit.nl	Samen Sterk Zonder Stigma (SSZS)
The Social Run	https://www.runsocial.com/	Social Run
Training Psychological diversity: ‘The Talk’	https://www.samensterkzonderstigma.nl/	Samen Sterk Zonder Stigma (SSZS)
Photovoice	https://www.rutgers.international/photovoice	-
CORAL and the BESIDES study	https://www.tilburguniversity.edu/research/institutes-and-research-groups/tranzo	Tranzo of Tilburg University
Hungary		
Community based activities, mental health promotion antistigma activities in mental health	https://ebredesek.hu/	Awakenings Foundation
Services for family members, mental health promotion antistigma activities in mental health	https://www.lelekbenotthon.hu/	Lélekben Otthon Alapítvány
Services in mental health	https://callforhelp.hu/vegeken/	Végeken Egészséglélektani Alapítvány (Végeken Mental Health Foundation)
Cummunity based activities, mental health promotion antistigma activities	https://www.egyensulyunkert.hu/	Egyensúlyunkért Alapítvány

antistigma activities in mental health	https://mok.hu/	Magyar Orvosi Kamara – Hungarian Medical Chamber
Aantistigma activities in mental health	https://mptpszichiatria.hu	Magyar Pszichiátriai Társaság – Hungarian Pszíchiatric Association
Cummunity based activities, mental health promotion antistigma activities	https://www.nnk.gov.hu/index.php	NNK – National Public Health Center
Cummunity based activities, mental health promotion antistigma activities	https://www.aeek.hu/web/national-healthcare-services-center/main-page	AEEK - National Healthcare Services Center
Antistigma activities in mental health	http://vegeken.hu/	Végeken Alapítvány
Antistigma activities - legal protection	https://tasz.hu/	Társaság a Szabadságjogokért
Antistigma activities - legal protection	https://www.amnesty.hu/	Amnesty International Hungary
Antistigma activities - legal protection	https://www.helsinki.hu/	Magyar Helsinki Bizottság - The Hungarian Helsinki Committee
Antistigma activities - legal protection	http://dev.neki.hu/	Nemzeti és Etnikai Kisebbségi Jogvédő Iroda
Antistigma activities - legal protection	http://www.kisebbsegiombudsman.hu/	Kisebbségi Ombudsman – Parlamentary Commissioner for the rights of national and ethnic minorities
Antistigma activities - legal protection for clients with mental health issues	http://www.nemzetibetegforum.hu/	Nemzeti Betegfórum – National Patient's Forum
Antistigma activities - legal protection for clients with mental health issues	https://www.pef.hu/	Pszichiátriai Érdekvédelmi Fórum - Psychiatric Patients Right Forum
Antistigma activities - legal protection for clients with mental health issues	http://www.ijsz.hu/	Integrált Jogvédelmi Szolgálat - Integrated Patients Rights Service
Antistigma activities - legal protection	https://mkik.hu/en	Kereskedelmi és Iparkamara - Hungarian Chamber of Commerce and Industry
Antistigma activities - legal protection	http://www.motesz.hu/	MOTESZ
Ireland		
See Change in Your Workplace	https://seechange.ie/see-change-in-your-workplace/	See Change
Kosovo		

PRAK -Shoqata e të Drejtave të Pacientëve në Kosovë (Patients' Rights Association in Kosovo)	http://prak-kosova.org/	Shoqata e të Drejtave të Pacientëve në Kosovë (Patients' Rights Association in Kosovo)
QIPS - Qendra për Informim dhe Përmirësim Social (The Centre for Information and Social Improvement)	http://qips-ks.org/	Qendra për Informim dhe Përmirësim Social (The Centre for Information and Social Improvement)
Klubi "Deshira" Clubhouse	https://www.facebook.com/KlubiDeshiraClubhouse	
National Institute of Public Health Kosova	http://niph-rks.org/	National Institute of Public Health Kosova
Finland		
Mieli – Mental Health Finland	https://mieli.fi/en	Mental Health Finland
Mielenterveyden keskusliitto	https://www.mtkl.fi/	Mielenterveyden keskusliitto
Psykosociala förbundet	https://www.fspc.fi/	Psykosociala förbundet
FinFami	https://finfami.fi/in-english/	FinFami
Mielenterveyspooli	https://mielenterveyspooli.fi/	Mielenterveyspooli
Anti-stigma programs listed by the experts in the Delphi study		
'I AM WHOLE'-campaign	https://www.whole.org.uk/	
'Accenture Allies Programme':	https://www.accenture.com/gb-en/company-accenture-allies-programmes	
Mielekäs työ by Mielenterveyspooli (translation: Mental Health Pool):	https://mielenterveyspooli.fi/	
Hyvän mielen työpaikka (translation: Brain Work)	https://www.ttl.fi/oppimateriaalit/en/	
MATES in Construction	https://mates.org.au/	
Samen Sterk zonder Stigma (translation: Strong Together without Stigma)	https://www.samensterkzonderstigma.nl/	
Per la Salut Mental, dóna la cara by Obertament	https://obertament.org/ca	
See change by Green Ribbon	https://seechange.ie/green-ribbon/	
'Health Day'	https://www.who.int/westernpacific/news/events/world-health-day	

‘World Mental Health Day’	https://www.who.int/campaigns/world-mental-health-day	
‘World Suicide Prevention Day’	https://www.iasp.info/wspd2020/	
German Depression Foundation	https://www.deutsche-depressionshilfe.de/start	
DIXIT TV	https://dixit.gencat.cat/en/01dixit/01que_es/	
Confederación Salud Mental España	https://consaludmental.org/	

Appendix 3.

Situation analysis anti-stigma practices in the Netherlands

Work package 4 MENTUPP consortium

MENTUPP Interventions for Stigma Reduction

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June 2020

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Background

The MENTUPP project aims to improve mental health and wellbeing in the workplace by developing, implementing and evaluating a comprehensive, multilevel intervention targeting both clinical (depressive, anxiety disorders) and non-clinical (stress, burnout, wellbeing, depressive symptoms) mental health issues, as well as combating the stigma of mental (ill-) health. This will be conducted through the execution of several work packages by an international consortium including experts from different countries worldwide.

One of the main work packages for the development of the MENTUPP intervention is work package 4: 'MENTUPP Interventions for Stigma Reduction'. For the development of an intervention targeting stigma reduction the MENTUPP partners were required to collect anti-stigma practices from their own country.

In this document we will give an overview of the anti-stigma practices targeting the workplace in the Netherlands. We retrieved these anti-stigma practices at the beginning of 2020 by utilizing two sources: 1. A consultation of relevant stakeholders that are implementing anti-stigma practices; 2. A grey literature search. This resulted in a total of five anti-stigma practices in the workplace currently executed in the Netherlands. In this document we will present these anti-stigma practices in an overview table, followed by a more detailed explanation and evaluation of each practice. An important note is that this document only focused on practices executed in the Netherlands or in the Dutch context. This could also contain evidence-based practices executed and investigated in other countries as well. In that case we will only focus on practice and research executed in the Netherlands.

Overview of anti-stigma practices

Name Best Practice	Retrieved through	Target group	Topic	Dissemination in the Netherlands	Publications in the Netherlands
E-Learning psychological diversity on the workplace	Grey literature search	1. Employees 2. Employers 3. Colleagues	Online tool giving insight into mental health problems in an employment setting and how to approach people with mental health problems	Openly available through a website	No publications in the Netherlands
The Social Run	Stakeholder consultations	All employers and employees	An event containing a team run with the whole organization focused on equality and openness on the job	Internationally executed and broadly disseminated through social media	No publications in the Netherlands
Training Psychological diversity: 'The Talk'	Grey literature search	Employers	An in-company training for employers focusing on improvement of noticing mental health problems and openly talking about these problems with employees	Not widely available nor broadly disseminated	No publications in the Netherlands

CORAL and the BESIDES study	Stakeholder consultations and Grey literature search	Health care professionals, counselors and employed clients	CORAL is a tool supporting clients and professionals in openly discussing the possibilities to reveal mental health problems on the workplace and making adequate decisions about this subject	Translated into Dutch and widely used during supported employment	First Dutch publication manuscript accepted
Photovoice	Grey literature search	Clients in health care settings	Photovoice is an expressive method helping people and their environment raising awareness about their personal and social roles through photography	The intervention is not evidence-based so it is not widely available yet.	A variety of international research has been executed

Practice 1

E-Learning psychological diversity on the workplace

Description of the organization

This Best Practice is implemented by an organization called 'Samen Sterk Zonder Stigma (SSZS)' (Free translation: Together Strong Against Stigma). SSZS is an organization that is focused on creating tools, interventions and applications targeting a decrease of stigma in society and an increase of openness about the topic of stigma and its impact. SSZS is primarily focused on mental health care, media, school, the workplace and neighborhoods.

Description of the content

The E-learning tool is a practical online tool for three target groups:

1. Employees with mental health problems;
2. Employers or managers of employees with mental health problems
3. Colleagues of people with mental health problems.

For those three target groups SSZS developed a brief e-learning tool that gives some insight and advice into mental health problems tailored for the different perspectives of each target group. For employees the tool is targeted on how to be open about mental health problems to their employer and colleagues. For employers the tool is focused on how to approach employees with mental health problems in different settings. For colleagues the tool is focused on how to handle and support their colleagues with mental health problems.

Publications and dissemination of the anti-stigma practice

The E-learning tool is openly and freely available for all employers, employees and colleagues who are interested in this topic in the Netherlands. The web link to the tool is https://e-learning.psychischediversiteit.nl/. The tool is not based on evidence based modalities and there are no scientific publications for the effectiveness of this tool.

SWOT analysis

We could only execute a SWOT analysis for the anti-stigma practices we retrieved through stakeholder consultations. As this practice is retrieved through grey literature search we did not carry-out a SWOT analysis on this topic.

Practice 2

The Social Run

Description of the organization

Social Run is an organization focused on activities targeting improvement of social inclusion in society. The organization is funded by sponsorships of organizations with affinity with the topic of social inclusion. The activities are focused on raising awareness of diversity and social inclusion and is not exclusively focused on the topic of stigma.

Description of the content

The Social Run is a long distance run, in which a team or organization can join. The run is taking 48 hours and both CEO's and their employees are requested to join in one team. Because of the long duration of the run, fixed social roles and positions disappear and both employers and employees will become equal and more open towards each other. The main goals of the Social Run is that companies become more open about topics such as stigma and social inclusion and achieve more appreciation towards each other.

Publications and dissemination of the anti-stigma practice

The Social Run is executed internationally. There are not only Social Runs in the Netherlands, but for example also in Bucharest or Sri Lanka. Furthermore, they have a website and they develop tools and films that are broadly disseminated. The Social Run is not evaluated and the stakeholders stated that it is not possible to evaluate this practice 'because it's hard to measure inclusion and execute a baseline measure'.

SWOT analysis

A SWOT analysis was executed through a stakeholder consultation by the director and developer of the Social Run.

Strengths:	Available for everybody
Weaknesses:	It is hard to find sufficient amount of sponsorship funding to keep this going
Opportunities:	No opportunities are reported
Threats:	The concept is open and easy to copy for other organizations.

Practice 3

Training Psychological diversity: 'The Talk'

Description of the organization

This practice is implemented by an organization called 'Samen Sterk Zonder Stigma (SSZS)' (Free translation: Together Strong Against Stigma). SSZS is an organization that is focused on creating tools, interventions and applications targeting a decrease of stigma in society and an increase of openness about the topic of stigma and its impact. The sectors that SSZS is most primarily focused on are mental health care, media, school, the workplace and neighborhoods.

Description of the content

This training is targeting employers, managers, Human Resources specialists and others who supervise and support employees on the workplace. The training entails education of psychological diversity on the workplace. Furthermore, the training is focused on raising awareness about prejudices of employers and it contains practical tools for how to talk and be open about mental health problems with the employee. The training also contains some conversation techniques with an actor to train the employers of how to talk about this topic and let them feel more comfortable about talking about this topic with the employee. The training will be executed in groups of eight to twelve persons and will last a day.

Publications and dissemination of the anti-stigma practice

This is an in-company training that will be executed by professionals and will cost € 2,545,- per training. The training is not widely available nor broadly disseminated. The training has not been investigated and there are no scientific publications for this training.

SWOT analysis

We only executed a SWOT analysis for the anti-stigma practices we retrieved through stakeholder consultations. As this practice is retrieved through grey literature search we did not carry-out a SWOT analysis on this topic.

Practice 4

CORAL and the BESIDES study

Description of the organization

The BESIDES study is executed by the department Tranzo of Tilburg University. Tranzo is a scientific center focused on health and well-being. Tranzo is working in co-creation with clinical practice to improve evidence-based practice within the health care sector. The main themes Tranzo is focused on are: quality of life, quality of care and implementation of evidence-based practices.

CORAL is implemented through 'Samen Sterk Zonder Stigma (SSZS)' (Free translation: Together Strong Against Stigma), Tranzo and Phrenos Center of Expertise for Severe Mental Illnesses. SSZS is broadly described in previous Best Practices and Phrenos is one of the international MENTUPP partner organizations.

Description of the content of the anti-stigma Best Practice

CORAL is an abbreviation for Conceal Or ReveAL. CORAL is a self-help tool and decision aid, originally developed in the UK, helping people to make their own choices about openness of their own mental health problems to their employer. CORAL is focused on instructing health care professionals and counselors to what extent they recommend clients with mental health problems who are starting a job to be open about their mental health problems. The tool is also focused on people with mental health problems themselves. The course is focused on giving tools to clients to make a thoughtful and personalized decision about openness to their employer. In the BESIDES study the effectiveness of CORAL on sustainable functioning on the workplace is longitudinally investigated.

Publications and dissemination of the anti-stigma Best Practice

CORAL has already been investigated in the UK (Henderson et al., 2013). In the Netherlands CORAL was translated and developed for the Dutch situation. Right now the effectiveness of CORAL is investigated in the BESIDES study and the study protocol has already been published (Janssens et al., accepted). In the Netherlands there was also a published stakeholder consultation about disclosure in the work environment (Brouwers et al., 2020). The first results are expected to be disseminated in 2021. In the Netherlands CORAL is already widely used as a tool during supported employment.

Dutch publications

Brouwers, E.P., Joosen, M.C., van Zelst, C. & Van Weeghel, J. (2020). To disclose or not to disclose: a multi-stakeholder focus group study on mental health issues in the work environment. *J Occup Rehabil.;30*(1):84–92.

Janssens KME, van Weeghel J, Henderson C, Joosen MCW, Brouwers EPM. Evaluation of an intervention to support decisions on disclosure in the employment setting (DECIDES): study protocol of a longitudinal cluster-randomized controlled trial. *Trials*. 2020;21(1):443. Published 2020 May 29. doi:10.1186/s13063-020-04376-1

International publications

Brohan E.M. (2010). *Disclosure of a mental health problem in the employment context: measurement of stigma and discrimination and development of a decision aid tool.* (Doctoral dissertation, King's College London Institute of Psychiatry, London; 2010).

Brohan E, Henderson C, Slade M, Thornicroft G. (2014). Development and preliminary evaluation of a decision aid for disclosure of mental illness to employers. *Patient Educ Couns. 2014;94*(2):238–42.

Henderson, C., Brohan, E., Clement, S., Williams, P., Lassman, F., Schauman, O., ... & Slade, M. (2013). Decision aid on disclosure of mental health status to an employer: feasibility and outcomes of a randomised controlled trial. *The British Journal of Psychiatry*, *203*(5), 350-357.

Henderson, C., Brohan, E., Clement, S., Williams, P., Lassman, F., Schauman, O., ... & Thornicroft, G. (2012). A decision aid to assist decisions on disclosure of mental health status to an employer: protocol for the CORAL exploratory randomised controlled trial. *Bmc Psychiatry*, *12*(1), 1-9.

SWOT analysis

Strengths:	Broad meetings with both clients and professionals are organized, increasing awareness for this topic.
Weaknesses:	It is hard to motivate professionals to execute the intervention.
Opportunities:	Raising awareness and openness of mental health problems in an employment setting.
Threats:	The program can be used to support an opinion of professionals, instead of using the facts as a tool to help people to make a thoughtful decision.

Practice 5

Photovoice

Description of the organization

Photovoice is an intervention that has been implemented in the Netherlands by some organizations. Therefore, we could not specifically describe one organization executing this intervention.

Description of the content of the anti-stigma Best Practice

Photovoice is an expressive method using photos and personal narratives of people with mental health problems. The users of Photovoice photographs their personal lives and environment to achieve three goals:

1. Capture their strengths and the community that could help the client with their mental health problems
2. The photos should capture themes that invite people to a critical conversation about sensible subjects, such as stigma.
3. The photos should reach a target group, such as policy makers or employers.

By sharing the experience and photos people with mental health problems and their environment will become more aware about their personal and social roles about this theme. Photovoice could help to clarify this image and supports people to work on topics related to stigma they want to improve.

Publications and dissemination of the anti-stigma Best Practice

Photovoice is primarily implemented in a mental healthcare setting. Studies have not indicated effectiveness of the intervention. Therefore, photovoice is not broadly implemented in a mental health care setting yet.

International publication list:

Andonian, L. (2010). Community participation of people with mental health issues within an urban environment. Occupational Therapy in Mental Health, 26(4), 401-417. doi:10.1080/0164212X.2010.518435

Cabassa, L. J., Nicasio, A., & Whitley, R. (2013). Picturing recovery: A Photovoice exploration of recovery dimensions among people with serious mental illness. Psychiatric Services, 64(9), 837-842. doi:10.1176/appi.ps.201200503

Cabassa, L. J., Parcesepe, A., Nicasio, A., Baxter, E., Tsemberis, S., & Lewis-Fernández, R. (2013). Health and wellness Photovoice project: Engaging consumers with serious mental

illness in health care interventions. Qualitative Health Research, 23(5), 618- 630. doi:10.1177/1049732312470872

Clements, K. (2012). Participatory action research and Photovoice in a psychiatric nursing/clubhouse collaboration exploring recovery narrative. Journal of Psychiatric and Mental Health Nursing, 19(9), 785-791. doi:10.1111/j.1365-2850.2011.01853.x

Fleming, J., Mahoney, J., Carlson, E., & Engebretson, J. (2009). An Ethnographic Approach to Interpreting a Mental Illness Photovoice Exhibit. Archives of Psychiatric Nursing, 23(1), 16-24. doi:10.1016/j.apnu.2008.02.008Gorzynsky, 2013).

Kreklewetz, C. (2010). Self-care of incest survivor mothers

Mizock, L., Russinova, Z., & Decastro, S. (2015). Recovery narrative Photovoice: Feasibility of a writing and photography intervention for serious mental illnesses. Psychiatric Rehabilitation Journal, 38(3), 279-282. doi:10.1037/prj0000111

Mizock, L., Russinova, Z., & Shani, R. (2014). New roads paved on losses: Photovoice perspectives about recovery from mental illness. Qualitative Health Research, 24(11), 1481-1491. doi:10.1177/1049732314548686 (Rosen et al., 2011),

Russinova, Z., Rogers, E. S., Gagne, C., Bloch, P., Drake, K. M., & Mueser, K. T. (2014). A randomized controlled trial of a peer-run antistigma Photovoice intervention. Psychiatric Services, 65(2), 242-246. doi:10.1176/appi.ps.201200572

Tang J.P.S., Tse S., Davidson L. (2016). The big picture unfolds: Using photovoice to study user participation in mental health services. International Journal of Social Psychiatry

Thompson, N. C., Hunter, E. E., Murray, L., Ninci, L., Rolfs, E. M., & Pallikkathayil, L. (2008). The experience of living with chronic mental illness: A Photovoice study. Perspectives in Psychiatric Care, 44(1), 14-24. doi:10.1111/j.1744- 6163.2008.00143.x

SWOT analysis

We only executed a SWOT analysis for the anti-stigma Best Practices we retrieved through stakeholder consultations. As this practice is retrieved through grey literature search we did not carry-out a SWOT analysis on this topic.

MENTUPP

Expert Consultation Report

Document date: 06/11/2020
Document version: 1.1

Full Name	Short Name	Beneficiary Number	Role
UNIVERSITY COLLEGE CORK – NATIONAL UNIVERSITY OF IRELAND, CORK	UCC	1	Coordinator
EUROPEAN ALLIANCE AGAINST DEPRESSION EV	EAAD	2	Beneficiary
KATHOLIEKE UNIVERSITEIT LEUVEN	KU Leuven	3	Beneficiary
DET NATIONALE FORSKNINGSCENTER FORARBEJDSMILJO	NRCWE	4	Beneficiary
TERVEYDEN JA HYVINVOINNIN LAITOS	THL	5	Beneficiary
THE UNIVERSITY OF STIRLING	NMAHP-RU	6	Beneficiary
SEMMELWEIS EGYETEM	SEM	7	Beneficiary
STICHTING KENNISCENTRUM PHRENOS	PHRENOS	8	Beneficiary
QENDRES SE SHENDETIT DHE MIREQENIES KOMUNITARE	CCHW	9	Beneficiary
ZYRA PER SHENDET MENDOR	ZSMKOS	10	Beneficiary
LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE ROYAL CHARTER	LHSTM	11	Beneficiary
CONSORCIO MAR PARC DE SALUT DE BARCELONA	IMIM	12	Beneficiary
NATIONAL SUICIDE RESEARCH FOUNDATION	NSRF	13	Beneficiary
INTERNATIONAL ASSOCIATION FOR SUICIDE PREVENTION	IASP	14	Beneficiary
PINTAIL LTD	PT	15	Beneficiary
GRIFFITH UNIVERSITY	AISRAP	16	Beneficiary
MATES IN CONSTRUCTION (AUST) LTD	MIC	17	Beneficiary

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1 Abstract

An expert consultation was carried out across 8 European countries and Australia, over a 3-week period between September and October 2020. The overarching aim of this consultation was, along with a revision of the extant scientific literature, to provide the evidence-base for the development of online tools to be used as part of the broader MENTUPP project. In this consultation, experts representing academic experts, small- and medium-sized enterprise (SME) or specific sector groups, labour groups, occupational health associate groups, and advocacy groups, provided their insights and assessments on the promotion of employee wellbeing and the specific non-clinical and clinical mental health needs of employees and employers in addition to identifying any gaps. Experts were also asked about the level of stigma and gaps in anti-stigma programs in relation to mental health in the workplace, gender-specific needs, the impact of the COVID-19 pandemic, and acceptability of interventions.

The survey was sent to 146 experts and 62 responded before the deadline, with a response rate of 42%. Results showed generally high agreement between the wide range of experts regarding a current unmet need for tools and materials to promote mental health and support employees with mental health difficulties in the workplace, and agreement on the types of materials required to meet this gap. There were more diverse answers regarding stigma and anti-stigma programs and gender-specific needs. There was a clear consensus regarding the negative impact of the COVID-19 pandemic on mental health symptoms and company capacity to promote wellbeing. Specific challenges regarding acceptability of the intervention were also raised.

The results of this report provide clear support for the MENTUPP project and approach and highlight specific challenges and needs to be taken into account when planning the intervention.

2 Introduction & Background

Depression and anxiety are the most prevalent disorders in the workplace in the EU (1) and cost the global economy $1 trillion each year in lost productivity (2). While the aetiology of mental disorder is complex, stress in the workplace is widespread, affecting 22% of the European workforce (3), and psychosocial job stressors, such as lack of decision latitude, job strain and bullying in the work environment can lead to depressive symptoms (4), and have been linked to suicidal ideation/behaviour (5).

Despite mental health issues being prevalent in the workplace, they are highly stigmatised, leading to discrimination in the workplace and the concealment of common mental disorders from employers (6). Stigma is a key factor in the under recognition and low treatment rates of mental illness (7,8) leading to indirect costs in the workplace (9).

Certain workplaces, due to company size or sector, have specific challenges. For example, healthcare employees and managers are regularly confronted with the stress of their patients, but are also subject to stress due to long working hours, understaffing, and excessive workload (10). Meanwhile, in construction, common psychosocial stressors include short term contracts and job uncertainty, long work hours and mental overload (11). In a 5-year study in England and Wales, the greatest number of

suicides was among construction workers, while the greatest proportional number of deaths in healthcare workers (12). Other challenges come from new and fast growing sectors such as Information and Communications Technology (ICT), where time pressure, work interruptions, multi-tasking and poor work/life balance are common, leading to stress, anxiety, burnout and worse self-reported health (13,14).

Small- and medium-sized enterprises (SMEs), defined in Europe as employing 250 people or less and having a maximum annual turnover of 50 million euros (15), employ a large faction of the workforce, accounting for 92.8% of the EU's non-financial economy in 2015 (16). SME employees and managers are exposed to a variety of work-related psychosocial factors which could put them at risk of depression and/or anxiety, including long working hours, low job control, and job insecurity (17), with SMEs particularly struggling in the wake of the COVID-19 pandemic (18). Studies among SME owners and managers have showed high percentages of stress, fatigue, presenteeism and depressed mood (19–21).

There is a growing body of literature providing evidence that psychosocial interventions can be effective in promoting mental health in the workplace (22–24), but there is a dearth of research regarding interventions specifically in SMEs. Interventions normally designed for large companies are not well adapted to SME needs and resources (20). SMEs do not generally have the resources to promote mental wellbeing that larger organisations have (25,26) or understand the business benefits of mental health promotion (27) and are significantly less likely to implement health promotion programs (28).

With this in mind, the MENTUPP project aims to improve mental health and promote wellbeing in the SME workplace by developing, implementing and evaluating a comprehensive, multilevel intervention targeting both clinical (depressive, anxiety disorders) and non-clinical (stress, burnout, wellbeing, depressive symptoms) mental health issues, as well as combating the stigma of mental (ill-) health. The intervention will be specifically tailored to SMEs in construction, healthcare and ICT and assessed in a multi-country Cluster Randomised Controlled Trial. The primary aim is to improve mental health in the workplace, with a secondary aim to reduce depression and suicidal behaviour.

To provide an evidence base for this intervention, a review of the extant literature reveals a lack of research specifically in SMEs, and a lack of knowledge specific to the sectors and countries of the MENTUPP intervention. Where there is insufficient scientific data, expert consensus can be used to inform the best approach to use (29). The Delphi process is a step-by-step process by which a consensus can be formed based on the opinions of a range of experts (see Figure 1), and has successfully been used to answer questions in mental health research on a wide range of topics (30). In this study, we carried out a first round Delphi process, collecting information in an expert consultation and allowing for the possibility of reaching a further consensus if needed, by carrying out a future round or rounds of the process.

Thus, this expert consultation was designed with the aim of investigating the experiences and needs of workplaces and SMEs with regards to the promotions of employee wellbeing, the prevention and

management of clinical and non-clinical mental health problems, and the reduction of stigma around mental health problems. Regarding this aim, our specific research questions are:

1. What is the current state of affairs in workplaces with regards to these topics?

2. What is the impact of the COVID-19 pandemic on mental health in workplaces?

3. What are the experiences in workplaces with existing interventions, policies and best practice around mental health and reducing stigma?

4. What needs do workplaces have in order to improve their activities to promote employee mental health and reduce stigma?

5. Which barriers and facilitators exist for the implementation of interventions in workplaces and specifically in the sectors of construction, health and ICT?

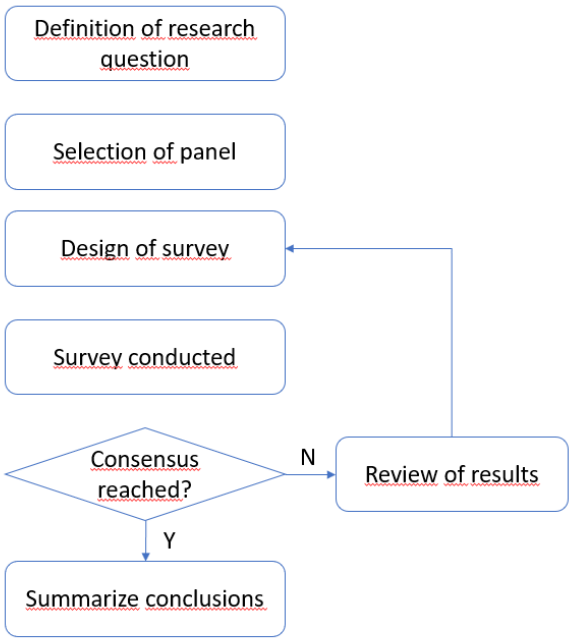

Figure 1. Delphi process

3 Method

3.1 Participants

The survey was distributed among academic experts, representatives of SMEs in general, representatives of the construction, healthcare or ICT sectors, or representatives of occupational health association groups, labour groups and advocacy groups. Only experts with at least 5 years of experience in their domain were targeted for this survey. Experts who were part of the MENTUPP consortium or under the age of 18 years were excluded.

The experts were recruited in the nine countries that will participate in the MENTUPP pilot trial and the cluster Randomised Controlled Trial (Albania, Australia, Finland, Germany, Hungary, Ireland,

Kosovo, the Netherlands, and Spain) and thus represent a diverse range of countries in terms of geography and income. To identify participants for this survey, different strategies were used including: networking (meaning recommendation by other experts in the field), identification through organization websites, and database search.

The research officers were asked to send the survey to at least 5 and up to 25 experts within their country. This range was chosen to take into account the different sizes of the participating countries and to ensure that the survey was completed in every country by a heterogeneous group of experts.

3.2 Ethical approval

Ethical approval for this study was received from the University College Cork Social Research Ethics Committee on 24/08/2020. All participants received information about the study and signed an informed consent before starting the survey.

3.3 Materials

A semi-structured Delphi-survey was designed, with a mix of open and closed questions, see Appendix 1. The survey questions were formulated based on the knowledge gaps identified following a review of the current literature. Questions were piloted with MENTUPP consortium members and external experts until a final version was agreed. The survey focused on seven topics as presented in Table 1 below:

Table 1: Survey Topics

Seven topics of the Delphi survey
General questions about you and your background
Workplace activity with regards to wellbeing and mental health
Impact of COVID-19 on mental health at work
Interventions aimed at the individual employee with regards to mental health
Anti-stigma activities
Gender-specific needs
Acceptability of workplace-based interventions

3.4 Procedure

The survey was sent out by research officers within each country to experts between 15th September 2020 and 5th October 2020. Before starting the survey, the selected experts received an information sheet and an informed consent form. Participation was completely voluntary and only proceeded when informed consent was given. The survey was estimated to take approximately 20 to 30 minutes to complete. Participants were able to save their answers and resume their survey at a later moment.

Multiple reminders were sent by the research officers within each country to encourage participants to start and/or complete the survey in time.

The survey platform 'Qualtrics' (www.qualtrics.com) was used to administer the English version of the survey to experts. For experts who didn't speak fluent English, the survey was translated into six additional languages (Albanian, Albanian for Kosovo, Dutch, German, Hungarian and Spanish) through a forward translation procedure. Every translation was reviewed by a native speaking research officer of the respective country. Local language surveys were not administered via Qualtrics but via Word or paper format. Experts then sent the completed local language survey to the research officer of their country and the research officers translated the answers into English and entered the responses into the Qualtrics software.

3.5 Analyses

Survey responses were analysed using descriptive statistics. For each item, the frequencies, the percentages, the median response, and the interquartile range (IQR; the distance between the 25th and the 75th percentiles) were calculated to determine the levels of agreement on the items. For the calculation of the median response and the IQR, the response category "don't know" was disregarded.

Free-text comments on the open questions were coded and collated using Dedoose, a software tool to analyse qualitative data, which resulted in a reduced number of answer categories. The different answer categories on the open questions were then summarised bullet wise, followed by the number of experts making this comment in brackets. Some answer categories are further specified in sub bullets.

4 Results

Across the nine countries, 146 experts were invited to take part in the Delphi survey. Of these, 62 participated, representing a 42% response rate. Detailed tables with results from each question can be found in Appendix 2.

4.1 Participants

The first section of the survey gathered demographic data about the participants and details of their field of expertise of the participants.

There was a slight majority of male participants, with the majority of participants between 40 and 49 years but ranging from 20-29 to 70+. In terms of participant country, 38.7% responded from Eastern Europe (Albania and Kosovo), 14.5% from Central Europe (Hungary), 8.0% from Anglo cultures (Australia and Ireland), 16.2% from Germanic Europe (Germany, The Netherlands), 8.1% from Nordic Europe (Finland) and 14.5% from Latin Europe (Spain). The data regarding the demographics of the participants are summarized in Table 2.

Table 2: Demographic characteristics of the participants

Personal characteristics of the participants	Frequency	Percentage
Gender		
Female	26	41.9 %
Male	34	54.8 %
Other	2	3.2 %
Age		
Between 20 to 29 years	3	4.8 %
Between 30 to 39 years	15	24.2 %
Between 40 and 49 years	20	32.3 %
Between 50 and 59 years	14	22.6 %
Between 60 and 69 years	7	11.3 %
70 years or older	3	4.8 %
Country		
Albania	16	25.8 %
Australia	2	3.2 %
Finland	5	8.1 %
Germany	4	6.5 %
Hungary	9	14.5 %
Ireland	3	4.8 %
Kosovo	8	12.9 %
Spain	9	14.5 %
The Netherlands	6	9.7 %

In Table 3, the expertise of the participants can be seen. The majority had 11-20 years of experience, and represented one of the sectors of construction, health or ICT, with healthcare being the sector with the greatest representation among those three sectors. With regards to SMEs, 6.5% came from an SME organisation and 17.7% of experts had specific expertise in mental health in SMEs.

Table 3. Field of expertise of the participants

Field of expertise of the participants	Frequency	Percentage
Type of representative		
Representative of construction, health or ICT sector	31	50 %
Academic expert	14	22.6 %
Representative of organisation providing services for SMEs or represent of a group of SMEs	4	6.5 %
Labour group, occupational health specialist association group, or advocacy group representative	5	8.1 %
Other	8	12.9 %
Years of expertise		
5 to 10 years	19	30.6 %
11 to 20 years	26	41.9 %
More than 20 years	17	27.4 %
Area of expertise		
SMEs	10	16.1 %
Mental health in SMEs	11	17.7 %
Construction sector	9	14.5 %
Healthcare sector	30	48.4 %
ICT sector	15	24.2 %
General	10	16.1 %

4.2 Workplace activity with regard to wellbeing and mental health

The second section of the survey focused on workplace activity with regard to wellbeing and mental health. Overall, the experts assessed that workplaces activities about wellbeing and mental health for the most part are not very developed. They assessed that workplaces to a certain extent create mentally healthy workplaces by offering flexible working conditions (14.5% to a large extent and 37.1% somewhat), but they also assessed a number of deficiencies, especially with regard to a systematic approach to reducing stigma and to promoting employees' mental wellbeing. Many experts (40.3%) did not know if workplaces conduct needs assessments to promote mental wellbeing.

Next, the experts assessed that workplaces need support for improving the promotion of employee mental wellbeing and the prevention of employee stress, burnout, depression and/or anxiety. Experts assessed that workplaces would particularly benefit from more information about "how to create

mentally healthy working conditions" (59.7% to a large extent, and 32.3% somewhat). In addition, experts also assessed that workplaces would benefit from more knowledge about how to establish policies about creating mentally healthy workplaces, how to strengthen people management skills among senior/HR staff and from information about factors contributing to work stress and burnout. There was also agreement that workplaces would benefit from materials about how to carry out a needs assessment to inform an organisational approach to promoting wellbeing, but here the answers were more diverse, which might also be due to a lack of knowledge about needs assessments.

In an open question, the experts were asked about what methods/policies/interventions, if any, work well and are accepted in terms of promoting employee mental wellbeing and preventing, detecting, and managing employee stress, burnout, depression, or anxiety. In summary, most comments regarding the experience with existing tools were about seminars or trainings offered either by third parties (24 experts) or directly in the workplace (13 experts). Experts also drew attention to the importance of workplace conditions or context like flexibility in working hours, promoting awareness about mental health or supporting management style for mental health at work (12 experts). The importance of manager/supervisor commitment to interventions for mental health interventions to work was especially emphasised, but experts also mentioned the important role of general skills in for example communication, conflict handling or self-motivation for mental health at work.

Finally, the majority of experts thought that businesses to a large extent or somewhat have negative outcomes related to poor employee mental health, especially with regard to absenteeism and presenteeism, but also with regard to difficulties to return to work and job turnover. In addition to these outcomes, experts also pointed to additional consequences of poor mental health at work in the form of, for example, interpersonal conflicts, misunderstanding, discrimination and stigma as well as accidents caused by a 'no-care' attitude, substance abuse and lower productivity.

4.3 Impact of COVID-19 on mental health at work

This block of questions focused on the impact of the COVID-19 pandemic on mental health at work. There was a high degree of consensus between experts that the COVID-19 pandemic has had a negative impact on mental health at work, with 77.4% of experts assessing that job stress and burnout have increased and 69.4% assessing that levels of depression, anxiety, and/or suicidal behaviour have increased. Experts were also in agreement that there has been a decrease in the capacity of workplaces to promote mental wellbeing (51.6%), a decrease in the capacity of workplaces to support employees with mental health conditions (48.4%) and a decrease in the capacity of managers to look after their own mental health needs (45.2%). Only the level of stigma surrounding mental health issues was felt to have stayed the same (50%).

Open text comments provided further information around the mainly negative impact of the pandemic. The top five negative impacts described were: 1) uncertainty about the future (13 experts), 2) negative social impact on employees (8 experts), 3) anxiety or fear of infection (7 experts), 4) rise in mental health problems (6 experts), and 5) more difficult working conditions (5 experts). Other comments highlighted the financial uncertainty faced by SMEs. While three quarters (56 of 74) of the

responses focused on the negative impact of the pandemic, 8 responses referred to pandemic-related changes which have had a neutral impact: 7 referred to neutral changes in the workplace such as changes in working processes, and one expert referred to the need for general role adjustment in each person's private life.

There were also 10 responses which found a silver lining to the pandemic. 5 experts highlighted positive experiences with working remotely, and 2 experts highlighted technological and digital growth. 1 expert each highlighted knowledge enhancement, a positive impact on mental health awareness and less pressure from daily life as ways COVID-19 has impacted positively.

In summary, there is clear consensus that COVID-19 had increased levels of non-clinical and clinical mental health problems, and reduced company capacity to manage these issues.

4.4 Interventions aimed at employees with mental health difficulties

This section focused on interventions for employees experiencing mental health difficulties. Results show that there is, in general, little support in the workplace for employees with mental health difficulties, and a high level of unmet need in terms of programs to prevent and treat mental health difficulties in employees. There exists general consensus that materials and tools of any type aimed at employees with mental health difficulties are lacking.

With regards to tools and materials for employees, more than 70% of experts assessed that the following would be useful: information about depression or anxiety and how to cope, interventions based on cognitive behavioural therapy (CBT), frameworks to guide addressing mental health issues with employee, frameworks to guide accessing health services, and frameworks to guide planning return after mental-health related absence. Between 60% and 70% of experts assessed that information about suicide and how to access help, face to face workshops on detecting and managing depression and/or anxiety, online tools to detect and manage depression and/or anxiety, interventions based on mindfulness or relaxation techniques and peer support interventions would be helpful. Online workshops aimed at detecting and managing depression/anxiety, and interventions based on other therapies, were assessed as useful by 56.5% and 32.3% of experts, respectively.

When ranked, experts rated materials providing 'information about depression or anxiety and how to cope', 'face-to-face workshops on detecting and managing depression and/or anxiety', and 'interventions based on CBT' as the top three types of tools most likely to be taken up by staff. Meanwhile, 'frameworks to guide planning return after mental-health related absence', 'information about suicide and how to access help', and 'frameworks to guide accessing health services' were ranked as the least likely to be taken up by staff, meaning that despite these being rated as useful in the previous question, experts viewed that these would be less likely to be taken up by staff.

There was general consensus that managers lack the knowledge and skills to detect a mental health condition in an employee, have a conversation about this or make adjustments to facilitate job retention or return to work.

With regards to tools and materials for supervisors, more than 60% of experts assessed that information about depression or anxiety and how to cope, information about suicide and how to

access help, guidelines on what to do if an employee is experiencing mental health issues, face to face workshops with healthcare professionals, guidelines on handling an employee's return following mental health related absence and peer-to-peer support would be useful.

4.5 Anti-stigma activities

This section of the survey concentrated on levels of stigma surrounding mental health difficulties, and existing anti-stigma activities and tools. The experts involved in the survey reported a lot of unmet need regarding the implementation of workplace-based anti-stigma and anti-discrimination programs; however, opinions were varied. For example, with regards to being able to speak openly about stress and mental health issues, most experts disagreed that there was open communication, but the answers were somewhat mixed. Workplaces do seem to take steps avoiding stigma and discrimination, according to 62.8% of the experts (but only to a small extent according to 46.8%, and not at all according to 16% respectively). Only 9.7% of experts stated that there are major steps taken against stigma and discrimination in the workplace.

Experts considered that employees were most likely to hide mental health difficulties, with the most common underlying reasons for hiding them being the fear of job loss, stigmatisation, rejection by colleagues and discrimination in general.

Of note, the experts agreed on various well-defined needs and strategies to target stigma and discrimination, with a high degree of agreement that the following were useful either to a large extent or somewhat: workshops on mental health given by an expert-through-experience (79.0%), counselling funded by work (77.4%), awareness campaigns (77.4%), and workshops on mental health given by a professional (75.8%).

Finally, experts assessed that managers would agree to the following statement about anti-stigma programs: 74.7% of the experts reported that managers may find that anti-stigma program have a positive impact ("to a large extent" and "somewhat" answers were taken together). 72.6% reported that managers may find in ''somewhat'' and ''to a large extent'' that anti-stigma program can increase wellbeing, and 69.4% may find that anti-stigma program also increase productivity.

4.6 Gender-specific needs

The results regarding gender-specific needs showed a lack of consensus between experts. This section comprised three open text questions which gathered many responses. Here, we have summarised the top two answers for each of the three questions, and in each case the top two results show contrasting views.

In response to the first open text question asking if there is any gender difference in terms of help-seeking behaviours related to mental health issues, 22 experts highlighted a large gender difference in terms of help-seeking behavior, with females more likely to ask for help and seek help sooner, while 9 experts asserted there was no gender difference. In response to the second question, asking whether there are any gender-specific aspects that should be considered when supporting an employee's mental health, 17 experts felt gender-specific aspects should be considered when supporting an employee's mental health while 10 experts felt that support is important for everyone regardless of

gender, so there shouldn't be gender differences. Finally, in response to the question on whether there are specific aspects to take into account in male-dominated or female-dominated workplaces in terms of creating a mentally healthy workplace, 23 experts felt that specific needs should be considered in male/female dominated workplaces, while 4 felt that support should not focus on gender specific needs but on making workplaces better in general for everyone.

Further responses to the above questions showed more differences in opinion. On the one hand were comments supporting gender differences, such as "Support for men should be written in male language so that men with a traditional masculine identify are reached (1 expert)"; Different language should be used in support for males (1 expert)", "Men tend to hide their problems and solve their problem themselves (1 expert)", and "especially older males are reluctant to seek help (1 expert)". These comments contrasted with others such as "Gender neutrality should be used in all support and communication (1 expert)" or "Gender inequalities in employment, working conditions, and work life balance are important to consider; both genders need to be treated equally (2 experts)". There were also relevant comments highlighting the extra pressure women may be under outside the workplace due to the additional household responsibilities traditionally assigned to females, as well as comments highlighting the need to support minorities, particularly those who are LGBTQI+.

4.7 Acceptability of workplace-based interventions

Experts assessed various concerns on the part of both managers and employees which could be a barrier to the acceptability of workplace-based interventions. A majority of experts felt a lack of resources for implementation, as well as employees using work time or resources to access interventions, would be concerns to a large extent, while hesitancy on the part of staff to participate, and feelings that the workplace is not responsible for employees' mental health or an appropriate setting for such interventions were rated by a majority as somewhat of a concern.

There was consensus that information on the economic benefits and testimonials from managers who have implemented mental health interventions may influence managers to a large extent in deciding whether or not to implement interventions in the workplace, while information on social benefits, scientific information were deemed somewhat important, as well as a simple implementation requiring minimal manager, HR and employee time.

Meanwhile, a majority of experts (69.4% in each case) felt that confidentiality, discrimination or stigma, and career progression or job security, could prevent employees from participating in mental health interventions.

There was lower consensus regarding the acceptability of online tools aimed at individual employees. A majority neither agreed nor disagreed that it could be uncomfortable to access online tools while at work, that access would be easy or that access on a smartphone would be easier. There was a wide spread of responses regarding possible negative repercussions for employees and businesses, and level of access to online tools, which would be interesting to further analyse by sector.

5 Discussion

This survey is the first to the authors' knowledge to gather information regarding mental health interventions in SMEs across Europe and Australia in seven languages. The results provide a clear impression of an unmet need in terms of mental health interventions in the workplace focusing on wellbeing, non-clinical and clinical mental health difficulties, and associated stigma.

In terms of wellbeing and reducing stress, the results from the consultation largely confirm, but also specify the needs and challenges workplaces face when trying to improve their activities for the promotion of employee wellbeing and the prevention of non-clinical mental health conditions. Of note, the fact that 40% of the experts do not know if workplaces use needs assessments for a more organizational level approach to promote mental wellbeing, points to needs assessment not playing a large role in many workplaces. This is important to note, as regular needs or risk assessments, including of the psychosocial work environment, are required by law by the EU Framework Directive on Safety and Health at Work (31).

The results regarding wellbeing and reducing stress will be used within the MENTUPP project to tailor the relevant intervention tools even more, i.e. to focus on providing sufficient information but also providing training so that workplaces can improve their knowledge and competencies about mental health and wellbeing at work. Together with knowledge from systematic literature reviews about organizational level mental health interventions in the three sectors (ICT, healthcare and construction), and a literature review about mental health intervention implementation, the expert consultation study provides valuable knowledge that can help design intervention tools that fit to workplaces' needs and support them in their efforts to promote employee wellbeing and prevent non-clinical mental health conditions.

Concerning mental health difficulties, results showed companies do not have the tools, knowledge, or skills to support employees experiencing these issues, agreeing with previous data showing a lack of capacity in SMEs to manage the return to work of those on sick leave due to mental health problems (32). The survey results concur with data on the difficulties people who suffer mental health difficulties can have in staying in the workforce, with depression the leading cause of disability around the world (33,34). Given the financial and social impact of this, supporting employees and managers in this area is an urgent need. The findings of this survey complement findings from a systematic review of the existing scientific literature and provide valuable information on how best the MENTUPP tools to support employees and managers with mental health difficulties can be developed for the SME workplace, with a focus on psychoeducational materials and workshops.

Concerning stigma regarding mental health difficulties, experts concurred that this is prevalent in the workplace, and currently there is a lack of well-known anti-stigma activities. However, the experts supported the importance of in-person interventions in tackling stigma, and the online solutions were also positively ranked by them. The findings support the tools planned and being produced for the Anti-Stig Harbour within the MENTUPP project.

With reference to the impact of the COVID-19 pandemic, experts' impressions point to this being overwhelmingly negative, leading to an increase in mental health symptoms and a decrease in the capacity of workplaces to support employees, and managers to manage their own mental health. These results underscore the need for interventions to be implemented which can adapt to the current pressures of the pandemic, in terms of content and method of delivery. While face-to-face workshops were more highly rated than online workshops by experts to tackle mental health difficulties and stigma, online workshops were also rated positively, and their role will be substantial in light of the pandemic.

The results in the gender section perhaps drew the most diverse answers, with many gender-specific needs and challenges highlighted by experts, while a significant minority asserted there should be no difference between genders. There were many interesting points made by only one or two experts which could reflect conditions specific to certain sectors or countries, such as "In Albanian workplaces, employees stick to gender roles and men and women socialise separately" or "Women more often work in settings with client and patient contact; in these settings there are more absences from work due to mental health issues". These answers would warrant a further analysis by sector and country. However, while there is discrepancy over to what extent gender-specific tools should be employed, the answers all share a common theme of the importance of ensuring there is no negative impact from gender. Based on these answers, while there is no consensus on whether the intervention should be gender-specific, it can be taken that it is important to ensure there is no gender bias in the language used, as well as to take into account different communication styles and levels of help-seeking behaviours when designing the intervention.

The results regarding acceptability of the intervention contrast with the clear expert perception of need for mental health interventions defined by the experts, showing that for a variety of reasons managers and employees may find aspects of a workplace-based intervention not acceptable. This supports prior research showing that SMEs are less likely to implement health promotion programs (McCoy et al., 2014) and suggests that it is necessary to invest in "selling" the business benefits of the intervention to improve take up.

Despite variation in the country and background in which the experts have their expertise, the results from the experts provide a clear indication of which tools and materials would be most useful in supporting employees and managers in the promotion of wellbeing and tackling mental health difficulties in the workplace, as well as potential issues in the acceptability of the interventions. The highest agreement between experts was reached in the section on the impact of the COVID-19 pandemic on work. These results provide clear guidelines to meet the overreaching aim of this Delphi consultation for these areas, which was to develop the corresponding MENTUPP tools. However, several areas showed a lower degree of consensus, such as with regards to gender-specific needs, or a lack of knowledge on the part of experts, such as the 40% unaware of whether legally required needs assessments are carried out. These results warrant further detailed analysis to understand if these results reflect between-country, cultural, or sector-specific differences. Based on this more detailed analysis, it can be decided if a further round of the Delphi survey is needed or if, instead, there are

country- or sector-specific needs to take into account in these areas which means reaching a consensus between the experts would not be a reasonable aim.

Overall, the results provide an extensive dataset of expert opinion from across Europe and Australia, providing, along with reviews of the existing literature, an evidence base for informing the interventions currently being developed for MENTUPP. The strengths of this expert consultation include its implementation in 9 countries in different geographical, cultural, and economic regions, and translation into 6 languages, as well as the semi-structured design allowing for the capture of a range of data. However, there were some important limitations. Expert consultations, while providing valuable information, are low in the hierarchy of evidence. However, for the specific objectives of this survey, it has provided useful guidance in specific areas where scientific literature is lacking. The response rate, at 42%, was relatively low. While the diverse pool of participants answering the survey is a strength, it is also a limitation in terms of trying to gain consensus between experts when their individual roles, sectors or countries may reflect different realities. Additionally, the distribution of participants per country was uneven, with Albania providing a quarter of the total experts, and three countries (Germany, Australia and Ireland) not meeting the minimum threshold of 5 experts per country. This, in addition to the overrepresentation of the health sector as compared to the ICT or construction sectors, may further have skewed the results.

6 Conclusion

These results demonstrate that there is expert consensus that current tools, materials and support are lacking for employees and managers to be able to promote wellbeing and cope with mental health difficulties in the workplace. Similarly, expert opinion is that employees often hide their mental health difficulties due to stigma, and appropriate anti-stigma programs are needed. The strong negative impact of the COVID-19 pandemic, as highlighted by the experts in this report, make the MENTUPP project more timely than ever. The results of this expert consultation support the approach taken within the MENTUPP program and provide specific details which can be used to ensure the intervention is appropriate across the different countries and sectors. Specific challenges highlighted regarding the acceptability of the intervention and mode of delivery will be considered in order to ensure the success of the project.

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8 Appendices

8.1 Appendix 1: The Expert Consultation

A) General questions about you and your background

1. Please indicate your gender:

a) Male
b) Female
c) Other/prefer not to say

2. Please indicate your age:

a) 20-29 years old
b) 30-39 years old
c) 40-49 years old
d) 50-59 years old
e) 60-69 years old
f) 70 years or older

3. Please indicate the country that you will refer to when providing your answers: (Drop-down list: *Albania, Australia, Finland, Germany, Hungary, Ireland, Kosovo, The Netherlands, and Spain***)**

4. Please mark the statement that best describe your expertise.

a) I represent an organisation representing the construction, health or information and communication technologies (ICT) sector
   Please briefly describe what type of organisation that is_____
b) I am an academic expert
   Please briefly describe your academic background and your area of research with relation to mental health at work:_____
c) I represent an organisation providing services for SMEs or representing a group of SMEs
   Please briefly describe what type of organisation that is_____
d) I am a labour group, occupational health specialist association group, or advocacy group representative
   Please describe shortly the type of organisation you represent_____
e) Other, please state: _____

5. How many years of previously mentioned expertise do you have?

5-10 years
11-20 years
+20 years

6. Please indicate if you have expertise in any specific area listed below (multiple boxes can be checked):

a) SMEs
b) Mental health in SMEs
c) Construction industry
d) Health care sector
e) IT and communication
f) My experience is general and not related to any of these sectors

Please provide us with your valuable opinion and answer this survey based on your relevant occupational experiences as you have detailed above. Please always respond to the questions in terms of the country you are based in (as indicated above), and any specific sector you represent, if applicable.

B. Workplace activity

Please respond to the following questions in the context of the period before the current pandemic. There will be space at the end of this section to add comments related to the COVID-19 pandemic.

1. **Workplace activities**
    a. **In your opinion, to what extent does the average workplace** (*To a large extent/Somewhat/ To a small extent/Not at all/ Don't know)*
        i. Create mentally healthy workplaces by, for example, providing flexible and supportive working conditions and/or avoiding stressful working conditions, such as long working hours, excessive workload or poor supervisory support
        ii. Have a strategic and coordinated organisational approach to promote employees' mental wellbeing
        iii. Carry out needs assessments among employees to inform an organisational approach to promote mental wellbeing.
        iv. Provide training for managerial/HR staff on promoting wellbeing in the workplace
        v. Provide psychological support services to employees (for example, counselling support and stress management training)
        vi. Have a strategic and coordinated organisational approach to reduce stigma related to mental health problems.

Comments: Please add any comments you would like to make with regard to workplace activities that address the promotion of mental wellbeing and the prevention, detection and management of stress, burnout, depression or anxiety:_____(*open text*)

2. **Access to information/tools/advice**

a. To what extent do you think workplaces would benefit from/ would like/ more/require increased availability of information, about the following topics (*To a large extent/Somewhat/To a small extent/Not at all/Don't know)*

- **i.** How to create mentally healthy working conditions
- **ii.** Factors contributing to work stress and burnout
- **iii.** How to establish policies about creating mentally healthy workplaces
- **iv.** How to carry out a needs assessment to inform an organisational approach to promoting wellbeing
- **v.** How to strengthen people management skills among senior staff/HR staff in order to detect and handle mental health problems

b. Do workplaces have any other needs when it comes to improving the promotion of employee mental wellbeing and the prevention of employee stress, burnout, depression and/or anxiety? *(open text_____)*

3. Experience with existing tools/interventions and challenges

a. Based on your experiences what methods/policies/interventions, if any, work well and are accepted in terms of promoting employee mental wellbeing and preventing, detecting, and managing employee stress, burnout, depression, or anxiety? *(open text)*_____

b. Can you suggest up to 5 key barriers that you are aware of or have experienced when implementing methods/policies/interventions aimed at promoting employee mental health?

1._____
2._____
3._____
4._____
5._____

c. Can you suggest up to 5 key things that you are aware of which have helped when implementing methods/policies/interventions aimed at promoting employee mental health?

1._____
2._____
3._____
4._____
5._____

4. Consequences

a. Based on your experiences to what extent do you perceive the following business outcomes to be related to poor employee mental health? *(To a large extent/Somewhat/To a small extent/Not at all/Don't know)*

i. Absenteeism
ii. Presentism in terms of lower productivity
iii. Difficulties in returning to work following absence
iv. Job turnover (employees with poor mental health resigning or being dismissed)
v. Other _____

5. **COVID-19: Impact of the COVID-19 pandemic on mental health at work**
   a. **To what extent do you think COVID-19 has impacted on: (***have increased/stayed the same/have decreased/don't know)*

      i. levels of job stress and burnout
      ii. levels of depression, anxiety and/or suicidal thoughts or behaviour
      iii. the capacity of workplaces to promote employee wellbeing
      iv. the capacity of workplaces to support employees with mental health conditions
      v. the capacity of business owners/managers to look after their own mental health needs
      vi. Stigma (negative attitudes/behaviours around mental health issues) surrounding mental health issues
      vii. Do you know of any challenges specific to SMEs? _____

   b. Please provide further details on the impact of COVID-19 on your area of expertise.*(open text:_____)*

C. Supporting the individual employee with mental health needs

Please respond to the following questions in the context of the period before the current pandemic.

1. **Support for employees**
   a. To what extent are the following measures of support available for employees showing signs of mental health difficulties such as depression, anxiety or self-harm/suicidal thoughts or behaviour?: *(To a large extent/Somewhat/To a small extent/Not at all/Don't know)*
      i. support for mental health issues supplied directly within the workplace
      ii. occupational health support supplied by a third party
      iii. support provided by healthcare insurance organised through the business
      iv. support from labour organisations
      v. Other, please state:_____

b. How do you estimate the current level of unmet need for programs aimed at preventing and treating mental health difficulties in employees? *(High/Medium/Low/No need/ Don't know)*

c. To what extent are the following materials/tools available, within the workplace, for employees with mental health issues such as depression, anxiety or suicidal thoughts or behaviour? (*To a large extent/Somewhat/To a small extent/Not at all/Don't know, (and tick box on side - would this be useful?)*

- **i.** materials providing information about depression or anxiety and how to cope
- **ii.** materials providing information about suicide and how to access help
- **iii.** face-to-face workshops on detecting and managing depression and/or anxiety
- **iv.** online workshops on detecting and managing depression and/or anxiety
- **v.** online tools to help to detect and manage depression and/or anxiety
- **vi.** interventions based on cognitive behavioural therapy, to help change negative thoughts and behaviours
- **vii.** interventions based on mindfulness or relaxation techniques
- **viii.** interventions based on other therapies (please specify_____)
- **ix.** peer-support interventions
- **x.** framework to guide addressing the issue with their employee
- **xi.** framework to guide accessing health services
- **xii.** framework to guide planning a return to work following mental-health related absence (recovery)
- **xiii.** Other, please state_____

d. Based on your knowledge or experience, can you suggest what types of tools are most likely to be taken up by staff in your sector who are experiencing mental health problems? Please list in order of preference:

1.
2.
3.
4.
5.

2. Support for managers

a. In your experience, to what extent do supervisors have the knowledge and skills to: *(To a large extent/Somewhat/To a small extent/Not at all/Don't know)*:

- **i.** detect a mental health condition in an employee
- **ii.** have a conversation with an employee about their mental health condition
- **iii.** make adjustments to facilitate job retention or return to work

b. To what extent do you think supervisors need the following materials/tools? *(To a large extent/Somewhat/To a small extent/Not at all/Don't know and tick box on side - would this be useful?)*

- **i.** Materials providing information about depression and anxiety
- **ii.** Materials providing information about suicide and how to assist someone who is suicidal
- **iii.** Guidelines on what to do if an employee is experiencing a mental health issue
- **iv.** Guidelines on handling an employee's return to work following mental-health related absence
- **v.** Guidelines on managing presentism
- **vi.** Face-to-face workshops with healthcare professionals
- **vii.** Online workshops with healthcare professionals
- **viii.** Links with associations who can provide guidance
- ix. Peer-to-peer support
- **x.** Other, please state.

D. Anti-stigma Activities

Please respond to the following questions in the context of the period before the current pandemic.

1. **Levels of stigma** (negative attitudes/behaviours around mental health issues)
   - **a.** To what extent have employees the chance to speak openly about their work stress, burnout feelings or mental health problems in the workplace? *(Strongly agree/agree/neither agree nor disagree/disagree/strongly disagree/don't know)*
   - **b.** To what extent do workplaces?: *(To a large extent/Somewhat/To a small extent/Not at all/Don't know)*
     - i. Have a visible approach to reduce bullying and discrimination related to mental health issues in the workplace.
     - ii. have policies on sharing information about employees' mental health problems in order to protect employees' privacy rights
     - iii. have policies to protect employees against discrimination and bullying due to their mental health problems
   - **c.** Based on your professional assessment, what is the most common employee attitude regarding openly expressing mental health problems? (*1- Hiding 2 3 4 5 - Full Transparency)*
   - **d.** Based on your professional assessment, what is a manager's/supervisor's most common attitude toward employee mental health problems? *(1- rejection 2 3 4 5 – Full acceptance)*
   - **e.** Based on your professional assessment, if someone with a mental health problem openly expresses this in the workplace:

i. What are the most common risks? *(Open text_____)*
ii. What are the most common benefits?*(Open text_____)*

2. **Activities to reduce stigma** (negative attitudes/behaviours around mental health issues)
   a. To what extent do you think workplaces need further tools to reduce stigma towards mental health problems in the workplace? *(To a large extent/Somewhat/To a small extent/Not at all/Don't know)*
      i. Printed materials about mental health
      ii. Online information materials
      iii. Counselling provided or funded by the workplace
      iv. Awareness campaigns
      v. Workshops about mental disorders and stigma led by a professional (e.g., psychologist)
      vi. Workshops about mental disorders and stigma led by a person with lived experience
      vii. Website about how to reduce stigma in the workplace
      viii. E-mail or chat options to discuss stigma
      ix. Other: Please state_____

   b. To what degree do you think managers would agree with the following statements about programs to reduce stigma (negative attitudes/behaviours around mental health issues)?
      (*To a large extent/Somewhat/To a small extent/Not at all/Don't know*)

      i. Anti-stigma programs can have a positive impact on the wellbeing of employees with mental health problems.
      ii. Anti-stigma programs can increase the wellbeing of the entire staff at a workplace
      iii. Anti-stigma programs can increase the productivity in the workplace

3. **Acceptability of anti-stigma interventions**
   a. What, if anything, do you consider to be the main barrier when conducting a mental health anti-stigma activity? (open text)

4. Are you aware of any mental health anti-stigma activities in your country? If yes, please list the name of the program(s):

E. GENDER

1. To what extent do you assess that there are gender differences in terms of help-seeking behaviours related to mental health issues in your area? *(open text)*

2. Do you think there are gender-specific aspects that should be considered when supporting an employee's mental health? *(open text)*

3. Do you think that specific aspects need to be considered in male dominated workplaces and female dominated workplaces in terms of creating a mentally healthy workplace? *(open text)*

F. ACCEPTABILITY

In this section, we would like you to assess factors which may influence the acceptability of an intervention in the area you are an expert for in terms of:

1. Acceptability for managers/supervisors

a. To what extent do you think that managers/supervisors might have the following concerns when it comes to implementing mental health interventions within the workplace? (*To a large extent/Somewhat/To a small extent/Not at all/Don't know)*

i. Thinking that the workplace is not responsible for employees' mental health
ii. Thinking that staff will hesitate to participate in interventions in the workplace
iii. Concern about lack of resources for implementation
iv. Concern about employees accessing interventions during work time or using work resources
v. The workplace is not the appropriate setting for such interventions
vi. Other, please state_____

b. To what extent do you think the following may influence managers/supervisors when deciding whether or not to implement mental health interventions within the workplace:(*To a large extent/Somewhat/To a small extent/Not at all/Don't know)*

i. Information on the economic benefits it could bring to the workplace
ii. Information on the social benefits it could bring to the workplace
iii. Testimonials from managers/supervisors who have implemented mental health interventions and noted positive changes within the business
iv. Scientific research on the benefits of mental health interventions
v. Simple implementation which requires minimal manager/HR time
vi. Minimal requirement of employee time
vii. Relevance to COVID-19 pandemic
viii. Other, please state

2. Acceptability for employees

a. Based on your experience to what extent do you think the following issues may prevent an employee from participating in mental health interventions within the workplace setting?(*To a large extent/Somewhat/To a small extent/Not at all/Don't know)*
   i. Concerns about confidentiality
   ii. Concerns about discrimination/stigma
   iii. Concerns about career progression/job security
   iv. Thinking that the workplace should not get involved when employees have mental health problems
   v. Other, please state_____

3. Acceptability of online tools for interventions aimed at individual employees

Please rate the following statements about accessing tools online in terms of agreement *(Likert 1-5 strongly agree, agree, neither agree nor disagree, disagree, strongly disagree):*

   vii. Employees may feel uncomfortable accessing online mental health interventions while being at work
   viii. Accessing an online intervention while in the workplace could have negative repercussions for the employee
   ix. Employees accessing an online intervention through the workplace could have negative repercussions for the employers/business/SME
   x. Employees in the area have easy access to a computer during working hours
   xi. It would be easier for employees to access an intervention through their personal smartphone.

4. Is there anything else you would like to tell us about mental health in the workplace or about implementing activities to support mental health in the workplace? Please add whatever you think is relevant. If you have specific knowledge about one of the three sectors (ICT, health, construction) please provide us with additional information with regard to these sectors and/or if you have specific knowledge about SMEs please provide us with additional knowledge with regard to SMEs (*open text*_____*)*

8.2 Appendix 2: Full results

8.2.1 Participant demographics and expertise

Personal characteristics of the participants	Frequency	Percentage
Gender		
Female	26	41.9 %
Male	34	54.8 %
Other	2	3.2 %
Age		
Between 20 to 29 years	3	4.8 %
Between 30 to 39 years	15	24.2 %
Between 40 and 49 years	20	32.3 %
Between 50 and 59 years	14	22.6 %
Between 60 and 69 years	7	11.3 %
70 years or older	3	4.8 %
Country		
Albania	16	25.8 %
Australia	2	3.2 %
Finland	5	8.1 %
Germany	4	6.5 %
Hungary	9	14.5 %
Ireland	3	4.8 %
Kosovo	8	12.9 %
Spain	9	14.5 %
The Netherlands	6	9.7 %

Field of expertise of the participants	Frequency	Percentage
Type of representative		
Represent of construction, health or ICT sector	31	50 %
Academic expert	14	22.6 %
Represent of organisation providing services for SMEs or represent of a group of SMEs	4	6.5 %
Labour group, occupational health specialist association group, or advocacy group representative	5	8.1 %
Other	8	12.9 %
Years of expertise		
5 to 10 years	19	30.6 %
11 to 20 years	26	41.9 %
More than 20 years	17	27.4 %
Area of expertise		
SMEs	10	16.1 %
Mental health in SMEs	11	17.7 %
Construction sector	9	14.5 %
Healthcare sector	30	48.4 %
ICT sector	15	24.2 %
General	10	16.1 %

Expertise of experts at country-level	Albania	Australia	Finland	Germany	Hungary	Ireland	Kosovo	Spain	NDL
Type of representative									
Represent of construction, health or ICT sector	8	1	0	4	4	0	6	5	3
Academic expert	4	1	2	0	0	2	0	3	2
Represent of organisation providing services for SMEs or represent of a group of SMEs	0	0	0	0	3	0	1	0	0
Labour group, occupational health specialist association group, or advocacy group representative	1	0	1	0	0	1	0	1	1
Other	3	0	2	0	2	0	1	0	0
Years of expertise									
5 to 10 years	5	1	3	1	2	0	3	2	2
11 to 20 years	7	1	2	1	5	1	2	3	4
More than 20 years	4	0	0	2	2	2	3	4	0

8.2.2 Workplace activity with regards to wellbeing and mental health

8.2.2.1 Activities in the average workplace

Activities in the average workplace	To a large extent (4)	Some-what (3)	To a small extent (2)	Not at all (1)	Don't know	M[1] (IQR)[2]
Create a mentally healthy workplace (e.g., flexible working conditions)	9 14.5%	23 37.1%	23 37.1%	6 9.7%	1 1.6%	3 (1)
A strategic and coordinated approach	5 8.1%	11 17.7%	33 53.2%	11 17.7%	2 3.2%	2 (1)

to promote employees' mental wellbeing						
Needs assessments among employees to inform an organisational approach to promote mental wellbeing	5 8.1%	11 17.7%	21 33.9%	0 0%	25 40.3%	2 (1)
Training for managerial/HR staff on promoting wellbeing in the workplace	4 6.5%	18 29%	21 33.9%	13 21%	6 9.7%	2 (1)
Psychological support services to employees (e.g., counselling support and stress management)	8 12.9%	15 24.2%	21 33.9%	15 24.2%	3 4.8%	2 (2)
A strategic and coordinated approach to reduce stigma related to mental health problems	4 6.5%	9 14.5%	17 27.4%	30 48.4%	2 3.2%	1.5 (1)

[1]M = Median. Central tendency, indicating what most experts believe

[2]IQR = Inter Quartile Range. The difference between the upper and lower quartile denotes the spread of the answers, with lower numbers denoting higher consensus.

Additional comments from experts (numbers in brackets following the comment denote the number of experts who made this comment):

- There are no mental health related activities in the workplace (5)
- Mental health promotion programs exist in the workplace, but are mainly focussing on stress-management and should be expanded to general mental health promotion (4)
- Certain programs concerning mental health promotion (not focussing on stress) are offered in the workplace e.g. group interventions, mates in construction or improving mental health literacy among managers (3)
- Little attention goes to promotion and prevention of mental health. Organizations need to create an environment where attention towards mental health grows and organizational solutions to ensure this (3)
- Organizations should follow the law on health and safety at work (1)

8.2.2.2 Needs of workplaces to access information, tools or advice

Needs of workplaces to access information, tools or advice on	To a large extent (4)	Some-what (3)	To a small extent (2)	Not at all (1)	Don't know	M (IQR)
How to create mentally healthy working conditions	37 59.7%	20 32.3%	3 4.8%	1 1.6%	1 1.6%	4 (1)
Factors contributing to work stress and burnout	34 54.8%	17 27.4%	9 14.5%	1 1.6%	1 1.6%	4 (1)
How to establish policies about creating mentally healthy workplaces	31 50%	23 37.1%	6 9.7%	0 0%	2 3.2%	4 (1)
How to carry out a needs assessment to inform an organisational approach to promoting wellbeing	21 33.9%	26 41.9%	12 19.4%	0 0%	3 4.8%	3 (1)
How to strengthen people management skills among senior/HR staff in order to detect and handle mental health problems	32 51.6%	21 33.9%	8 12.9%	1 1.6%	0 0%	4 (1)

Other needs of workplaces with regard to improving the promotion of employee mental wellbeing and the prevention of employee stress, burnout, depression and/or anxiety:

- More financial resources (7)
- Gaining information on good results/successes in other companies (5)
- Commitment of managers/supervisors (5)
- Having access to a mental health professional (e.g. occupational health professionals) (4)
- More awareness concerning mental health in the workplace (4)
- Systematic changes in the culture of organisations (4)
- Commitment of employees (3)
- More human resources (2)
- (Group) activities that tackle stress or relaxation (2)
- An action plan (2)

- Improved working conditions (e.g. no precarious work anymore, better hygienic conditions) (2)
- An integrated intervention that links mental health to working ability (1)
- Changes at the national policy level (1)
- Small hands-on interventions for in the workplace (1)
- Peer support through mentoring programs (1)
- Equal treatment of all employees (1)
- A personal approach in the workplace: being able to differentiate between employees (1)

8.2.2.3 Experience with existing tools/interventions and challenges

Methods, policies, interventions, that work well and are accepted in terms of promoting employee mental wellbeing and preventing, detecting, and managing employee stress, burnout, depression, or anxiety:

- Interventions by third parties (e.g., seminars, trainings, mental health initiatives, etc.) work well and are accepted (24)
    - Hiring a mental health professional to tackle mental health related topics in the workplace (8)
    - Referring to a mental health professional outside the workplace (5)
    - Mental Health First Aid (2)
    - MATES in construction (1)
    - Balint Group network (i.e., a specific networking platform to join clinical psychologists and patients) (1)
- Interventions provided directly in the workplace work well and are accepted when proper assessment, organizational change and follow-up of mental health related topics is realized (13)
    - Continuous training of staff (3)
    - Logistic changes (e.g., relax room) (2)
    - Staff-meeting in which mental health issues can be discussed (2)
    - 'Health day': once a year promoting healthy habits (1)
- Workplace conditions/context (e.g., flexibility in working hours, promoting awareness about mental health or supporting management style) is important for methods/policies/interventions to work well (12)
- Methods/policies/interventions need the commitment of managers or supervisors in order to work well and be accepted (10)
    - Open-door policy, where management is approachable at any time (1)
    - Development of management skills in senior staff (1)
    - Role modelling (1)
    - Assertive managing style (1)
    - People-oriented style is important (1)

- Interventions that aim to enhance general skills (i.e., skills not specifically related to mental health) (e.g., communication skills, conflict handling, self-motivation, etc.) work well and have a positive effect on mental health (5)
- Interventions that aim to enhance employees' knowledge work well and are accepted (4)
- Peer-related interventions work well and are accepted (4)
- All stakeholders should be gathered for a method/policy/interventions to work well and be accepted (2)
- Laws related to mental health responsibility in the workplace are important concerning the acceptance of initiatives (2)
- Provision of counselling resources to fund initiatives (2)
- Rewards for employees, both financial and material rewards (e.g., Vitality Bonus) (2)
- Availability of evidence-based psychiatric interventions works for diagnosed disorders (1)
- Focusing on the benefits that can be achieved when employees and employers are mentally healthy (1)
- Keeping a practical and factual approach (1)

Key barriers when implementing methods/policies/interventions aimed at promoting employee mental health:

- Mental health issues are not regarded as a priority in the business (19)
- Financial or budgetary issues (e.g., lack of funding, costs are too high, etc.) (12)
- Fear for possible negative effects on career (e.g., job loss, loss of status, etc.) (11)
- Fear to open up about mental health, due to fear of prejudice by others (11)
- Insufficient knowledge about mental health methods/policies/interventions (11)
- Problems related with time-management (11)
- Stigma (11)
- Lack of commitment from managers/supervisors (10)
- The approach is too generic or insufficient (9)
- Confidentiality issues by employers or mistrust from employees (9)
- Lack of policy addressing mental health (8)
- Experiencing internal resistance (e.g., resistance to change and accept help) (8)
- Lack of available and/or competent professionals (6)
- An organisational culture that is not focused on mental health (6)
- Loss of productivity when focusing on mental health issues (5)
- Disinterest from employees (5)
- General disinterest (5)
- Lack of organisational structures that provide mental health (5)
- Mental health issues are not recognized (4)
- Hierarchy in the organisation (4)
- Societal impact that sets an unhealthy norm (e.g., crying is weak, stress is normal, …) (4)
- Results are holding off (3)
- Competing needs and interests concerning mental health (3)

- Problems concerning privacy (e.g., lack of discretion) (2)
- Self-stigmatization (2)
- Bureaucratic approach to mental health (1)

Key facilitators when implementing methods, policies and interventions aimed at promoting employee mental health:

- Strengthen the commitment of managers/supervisors (14)
- Build informal, personal relations through which stigma reduces and conversation about mental health issues can occur (13)
- Develop and follow strict guidelines on conversations on mental health (e.g., in weekly meetings, through gatekeepers, by communication with HR responsible, conversations with supervisor, linked with business goals) (11)
- Invest in trainings, programs or psychoeducation on communication, mental health, relaxation or healthy lifestyle (11)
- Enable flexibility in the workplace concerning working hours and adaptation of tasks if needed (11)
- Develop positive awareness in company's culture (11)
- Increase knowledge through e.g. scientific literature, education and facts (11)
- Collaborate with mental health organisations (9)
- Build interest in promotion and prevention of mental health through media campaigns (7)
- Assess mental health issues through assessments (6)
- Invest in clear and honest communication (6)
- Create a safe environment (e.g., balanced workload, stable workplace, psychological safety, diversity) (6)
- Organise peer support (e.g., buddy-systems) (6)
- Perform interventions directly in the workplace (6)
- Invest in long-term strategic planning of mental health promotion (5)
- Approach mental health issues with care (5)
- Encourage self-disclosure in employees by e.g. talking in smaller groups, sharing personal benefits (5)
- Formalize mental health by reminding employees about their rights in the workplace (5)
- Stimulate the interest of employees (5)
- Stress the financial benefits of mental health interventions (4)
- Stress the influence of mental health problems on work places and society (4)
- Invest in time management and planning of mental health interventions (4)
- Align the needs of all actors (e.g., stakeholders, overall organization) (4)
- Collaborate with labour or trade unions to facilitate implementation of mental health promotion and prevention (4)
- Learn from positive experiences of other companies and from previous successes (3)
- Organize social activities with the work community to enhance interrelations (3)
- Provide financial support through funding or extra resources for the organisation (3)

- Facilitate early detection of mental health problems (2)
- Refer employees towards mental health professionals outside the company (2)
- Provide logistic facilities (e.g., fruit day or relax rooms) (2)
- Moderate conflicts and work towards consensus (2)
- Provide economic or other rewards for employees (2)
- Induce role modelling by management (1)

8.2.2.4 Business outcomes related to poor employee mental health

Business outcomes related to poor employee mental health	To a large extent (4)	Some-what (3)	To a small extent (2)	Not at all (1)	Don't know	M (IQR)
Absenteeism	26 41.9%	27 43.5%	7 11.3%	0 0%	2 3.2%	3 (1)
Presenteeism	26 41.9%	23 37.1%	11 17.7%	0 0%	2 3.2%	3 (1)
Difficulties to return to work after absence	29 46.8%	19 30.6%	11 17.7%	2 3.2%	1 1.6%	3 (1)
Job turnover (resigning or being dismissed)	24 38.7%	24 38.7%	9 14.5%	3 4.8%	2 3.2%	3 (1)

Other business outcomes that are related to poor employee mental health:

- More interpersonal conflicts resulting in poor team work and a negative atmosphere (4)
- Misunderstanding, discrimination and stigma (4)
- Accidents caused by poor working quality or 'no-care' attitude (2)
- Lower productivity (2)
- Substance abuse (e.g. alcohol) (2)
- Difficulties in recruitment (1)
- Disability pensions (1)

8.2.3 Impact of COVID-19 on mental health at work

Impact of COVID-19 on	Have increased (3)	Stayed the same (2)	Have decreased (1)	Don't know	M (IQR)
Levels of job stress and burnout	48 77.4%	9 14.5%	4 6.5%	1 1.6%	3 (0)
Levels of depression, anxiety and/or suicidal behaviour	43 69.4%	10 16.1%	1 1.6%	8 12.9%	3 (0)
The capacity of workplaces to promote mental wellbeing	13 21%	14 22.6%	32 51.6%	3 4.8%	1 (1)
The capacity of workplaces to support employees with mental health conditions	10 16.1%	19 30.6%	30 48.4%	3 4.8%	1 (1)
The capacity of managers to look after their own mental health needs	12 19.4%	15 24.2%	28 45.2%	7 11.3%	1 (1)
Stigma of mental health issues	10 16.1%	31 50%	7 11.3%	14 22.6%	2 (0)

Negative impact due to COVID-19:

- Uncertainty about the future of the workplace or own career at the workplace (13)
- Negative social impact on the employees through e.g. isolation, feeling lonely or feeling detached (8)
- Anxiety or fear due to possible infection by COVID-19 virus (7)
- Rise in mental health problems (6)
- More difficult working conditions (e.g., working more hours due to difficulties in demarcating work hours from other hours, working more hours without any compensation or in conditions with high protection measures) (5)
- Financial worries on a business level (e.g., increase in costs through spending on materials and on a personal level, financial income) (4)
- Insecurity and worries about the future of the business and of jobs (3)
- Negative impact on employees' physical health (e.g., exhaustion) (2)
- Negative impact of remote work: diminished capacity to support employees (2)
- Higher risks and costs for SMEs (e.g., dismissals) due to less employees (2)
- Managing employees who struggle with isolation and balancing private and professional life (2)

- Employees who have to leave to manage personal affaires due to COVID-19 challenges (2)
- Increased tension between co-workers on topics such as who can work from home (2)
- The rights of psychiatric clients were violated (1)
- Especially in small enterprises, workers should be covered by representatives of a union (1)
- Difficulty to ensure qualitative staff when it is necessary to increase the workforce in order to maintain competitive capacity and to maintain capacity of growth (1)
- No support for occupational health professionals who worked full time since the start of the pandemic (1)
- Technical difficulties (1)

Neutral changes due to COVID-19:

- The workplace underwent several neutral changes (e.g., change in working processes, working hours, hygienic rules or only focusing on essential services) (7)
- Need for general role adjustment in private life of both employees and managers (1)

Positive impact due to COVID-19:

- Positive experience with working remote (5)
- Technological and digital growth thanks to necessary changes (2)
- Knowledge enhancement due to COVID-19 impact (1)
- Positive impact on mental health awareness (1)
- Less pressure from daily life (1)

8.2.4 Interventions aimed at employees with mental health difficulties

8.2.4.1 Available measures of support for employees with mental health difficulties

Available measures of support for employees with mental health difficulties	To a large extent (4)	Some-what (3)	To a small extent (2)	Not at all (1)	Don't know	M (IQR)
Support supplied directly within the workplace	6 9.7%	12 19.4%	24 38.7%	17 27.4%	3 4.8%	2 (2)
Support supplied by a third party	9 14.5%	18 29%	23 37.1%	10 16.1%	2 3.2%	2 (1)
Support provided by health insurance through the business	4 6.5%	16 25.8%	20 32.3%	15 24.2%	7 11.3%	2 (2)
Support from labour organisations	4 6.5%	10 16.1%	20 32.3%	22 35.5%	6 9.7%	2 (2)

Other available measures of support for employees showing signs of mental health difficulties:

- Informal support from the close social network (family, friends, colleagues, etc.) (4)
- Public health care services (4)
- Financial support for mental health treatment (1)

8.2.4.2 Level of unmet need for programs to prevent and treat mental health difficulties in employees

	High (4)	Medium (3)	Low (2)	No need (1)	Don't know	M (IQR)
Current level of unmet need for prevention and treatment programs for employees	28 45.2%	22 35.5%	6 9.7%	0 0%	6 9.7%	3,5 (1)

8.2.4.3 Available materials and tools for employees with mental health difficulties

Available materials and tools for employees with mental health difficulties	To a large extent (4)	Some-what (3)	To a small extent (2)	Not at all (1)	Don't know	M (IQR)
Information about depression or anxiety and how to cope	8 12.9%	9 14.5%	16 25.8%	23 37.1%	3 4.8%	2 (2)
Information about suicide and how to access help	3 4.8%	10 16.1%	15 24.2%	29 46.8%	3 4.8%	1 (1)
Face-to-face workshops on detecting and managing depression and/or anxiety	3 4.8%	10 16.1%	18 29%	23 37.1%	5 8.1%	2 (1)
Online workshops on detecting and managing depression and/or anxiety	2 3.2%	10 16.1%	16 25.8%	23 37.1%	8 12.9%	2 (1)
Online tools to detect and manage depression and/or anxiety	4 6.5%	11 17.7%	17 27.4%	22 35.5%	5 8.1%	2 (2)

Interventions based on cognitive behavioural therapy	2 3.2%	9 14.5%	15 24.2%	26 41.9%	7 11.3%	1,5 (2)
Interventions based on mindfulness or relaxation techniques	4 6.5%	15 24.2%	17 27.4%	18 29%	3 4.8%	2 (2)
Interventions based on other therapies*	1 1.6%	7 11.3%	6 9.7%	8 12.9%	13 21%	2 (2)
Peer support interventions	6 9.7%	9 14.5%	22 35.5%	16 25.8%	6 9.7%	2 (2)
Frameworks to guide addressing mental health issues with employee	5 8.1%	8 12.9%	14 22.6%	25 40.3%	6 9.7%	2 (2)
Frameworks to guide accessing health services	7 11.3%	7 11.3%	27 43.5%	13 21%	5 8.1%	2 (1)
Frameworks to guide planning return after mental-health related absence	7 11.3%	8 12.9%	15 24.2%	21 33.9%	8 12.9%	2 (2)

***Interventions based on other therapies:**

- Group therapy (4)
- Acceptance and Commitment Therapy (1)
- 'Anger' therapy (1)
- 'Anti-stress' therapy (1)
- Animal assisted therapy (1)
- Dialectical Behaviour Therapy (1)
- Employee Assistance Program (1)
- Solution Focused Therapy (1)
- A multimethod approach (1)

Other materials or tools that are available within the workplace for employees with mental health issues:

- Collegiality reports (1)
- Managing bullying (1)
- Health assessments by own staff (1)
- Organizational psychologists to conduct systematic assessments in the workplace (1)

Would the following materials or tools be useful for employees?	Yes	No
Information about depression or anxiety and how to cope	44 71%	6 9.7%
Information about suicide and how to access help	38 61.3%	8 12.9%
Face-to-face workshops on detecting and managing depression and/or anxiety	40 64.5%	8 12.9%
Online workshops on detecting and managing depression and/or anxiety	35 56.5%	15 24.2%
Online tools to detect and manage depression and/or anxiety	38 61.3%	12 19.4%
Interventions based on cognitive behavioural therapy	44 71.0%	4 6.5%
Interventions based on mindfulness or relaxation techniques	42 67.7%	6 9.7%
Interventions based on other therapies	20 32.3%	5 8.1%
Peer support interventions	43 69.4%	4 6.5%
Frameworks to guide addressing mental health issues with employee	44 71.0%	4 6.5%
Frameworks to guide accessing health services	44 71%	4 6.5%
Frameworks to guide planning return after mental-health related absence	46 74.2%	2 3.2%

For the item **"Types of tools for employees with mental health difficulties that are most likely to be taken up by staff"** experts were asked to make a ranking of the five most preferred tools. The table below presents for each tool the frequency of rank orders (e.g., materials providing information about depression or anxiety received rank 1 from 11 respondents). The column "total" is the weighted sum of ranking with a higher score indicating that more participants preferred that tool. The column "rank" is the final ranking of each tool with "materials providing information about depression or anxiety and how to cope" being ranked as the tool that is most likely to be taken up by the staff.

Types of tools that are most likely to be taken up by the staff	Rank 1 (freq.)	Rank 2 (freq.)	Rank 3 (freq.)	Rank 4 (freq.)	Rank 5 (freq.)	Total	Rank
Materials providing information about depression or anxiety and how to cope	11	6	3	6	4	104	1
Information about suicide and how to access help	0	6	1	2	5	36	10
Face-to-face workshops on detecting and managing depression and/or anxiety	14	4	3	1	4	101	2
Online workshops on detecting and managing depression and/or anxiety	3	8	2	3	3	62	5.5
Online tools to detect and manage depression and/or anxiety	2	4	9	3	3	62	5.5
Interventions based on cognitive behavioural therapy	0	5	9	9	4	69	3
Interventions based on mindfulness or relaxation techniques	3	2	4	6	4	51	8
Peer support interventions	4	5	4	6	4	68	4
Frameworks to guide addressing mental health issues with employee	7	2	3	2	4	60	7
Frameworks to guide accessing health services	1	1	4	1	3	26	11
Frameworks to guide planning return after mental-health related absence	3	3	0	6	5	44	9

8.2.4.4 Knowledge and skills of managers

Knowledge and skills of managers to	To a large extent (4)	Some-what (3)	To a small extent (2)	Not at all (1)	Don't know	M (IQR)
Detect a mental health condition in an employee	10 16.1%	7 11.3%	29 46.8%	14 22.6%	2 3.2%	2 (1)
Have a conversation about employee's mental health condition	8 12.9%	10 16.1%	28 45.2%	16 25.8%	0 0%	2 (2)
Make adjustments to facilitate job retention or return to work	8 12.9%	9 14.5%	27 43.5%	14 22.6%	4 6.5%	2 (1)

8.2.4.5 Needs of managers

To what extent need managers the following tools or materials	To a large extent (4)	Some-what (3)	To a small extent (2)	Not at all (1)	Don't know	M (IQR)
Materials providing information about depression or anxiety and how to cope	29 46.8%	17 27.4%	6 9.7%	4 6 %	2 3.2%	4 (1)
Materials providing information about suicide and how to access help	24 38.7%	15 24.2%	9 14.5%	6 9.7%	3 4.8%	3 (2)
Guidelines on what to do if an employee is experiencing mental health issues	40 64.5%	10 16.1%	2 3.2%	6 9.7%	2 3.2%	4 (1)
Guidelines on handling an employee's return following mental health related absence	37 59.7%	11 17.7%	2 3.2%	7 11.3%	2 3.2%	4 (1)
Guidelines on managing presentism	27 43.5%	14 22.6%	4 6.5%	7 11.3%	7 11.3%	4 (1)
Face-to-face workshops with	27	19	6	6	1	3

healthcare professionals	43.5%	30.6%	9.7%	9.7%	1.6%	(1)
Online workshops with healthcare professionals	23 37.1%	17 27.4%	8 12.9%	8 12.9%	2 3.2%	3 (2)
Guidance from linked associations	23 37.1%	20 32.3%	9 14.5%	6 9.7%	0 0%	3 (2)
Peer-to-peer support	26 41.9%	17 27.4%	8 12.9%	6 9.7%	1 1.6%	3 (2)

Would the following materials or tools be useful for supervisors?	Yes	No
Information about depression or anxiety and how to cope	42 67.7%	4 6.5%
Information about suicide and how to access help	42 67.7%	4 6.5%
Guidelines on what to do if an employee is experiencing mental health issues	42 67.7%	5 8.1%
Guidelines on handling an employee's return following mental health related absence	40 64.5%	5 8.1%
Guidelines on managing presentism	37 59,7%	4 6,5%
Face-to-face workshops with healthcare professionals	41 66.1%	4 6.5%
Online workshops with healthcare professionals	35 56.5%	8 12.9%
Guidance from linked associations	37 59.7%	6 9.7%
Peer-to-peer support	39 62.9%	4 6.5%

Other materials or tools supervisors need according to experts:

- Information on LGBTQI+ (1)
- Knowledge and skills on how to promote employee's mental health at work (1)
- Problem-Centred Interventions (1)

8.2.5 Anti-stigma activities

8.2.5.1 Levels of stigma and common attitudes of employees and employers

Level of stigma	Strongly agree (5)	Agree (4)	Neutral (3)	Disagree (2)	Strongly disagree (1)	Don't know	M (IQR)
Employees can speak openly about their work stress, burnout feelings or mental health problems	7 11.3%	9 14.5%	11 17.7%	20 32.3%	9 14.5%	6 9.7%	2 (2)

To what extent do workplaces	To a large extent (4)	Some-what (3)	To a small extent (2)	Not at all (1)	Don't know	M (IQR)
Have a visible approach to reduce bullying and discrimination related to mental health issues in the workplace	6 9.7%	12 19.4%	29 46.8%	10 16.1%	5 8.1%	2 (1)
Have policies on sharing information about employees' mental health problems in order to protect employees' privacy rights	8 12.9%	14 22.6%	22 35.5%	15 24.2%	0 0%	2 (2)
Have policies to protect employees against discrimination and bullying due to their mental health problems	5 8.1%	13 21.0%	25 40.3%	16 25.8%	0 0%	2 (2)

Common attitudes of employees and employers	Hiding (1)	(2)	(3)	(4)	Full transparency (5)	M (IQR)
What is the most common employee attitude towards openly expressing mental health issues?	28 45.2%	22 35.5%	8 12.9%	2 3.2%	0 0%	2 (1)

Common attitudes of employees and employers	Rejection (1)	(2)	(3)	(4)	Full acceptance (5)	M (IQR)
What is a manager's most common attitude towards employees openly expressing mental health issues	11 17.7%	16 25.8%	24 38.7%	6 9.7%	3 4.8%	3 (1)

The most common risks of employees openly expressing mental health problems:

- Job loss through dismissal (16)
- Stigmatization (16)
- Being rejected by colleagues or subgroups in the workplace (13)
- Discrimination in general (i.e., being treated differently because of mental health problems) (10)
- Getting unsupportive responses that may increase mental health problems (e.g., not be taken seriously, minimalization, inappropriate advice, misunderstanding) (8)
- Becoming less valuable in the organization's point of view (5)
- Negative influence on later career path (4)
- Bullying (2)
- Colleagues and managers might experience mental health problems as too much to handle (1)
- Being personally exposed (1)

The most common benefits of employees openly expressing mental health problems:

- Getting support from colleagues or managers in the workplace (16)
- Colleagues and managers will be more understanding (11)
- Facilitating help and/or receiving suggestions for help seeking (9)
- Creating a possibility to adjust working conditions according to the employee's needs (9)
- De-stigmatization of mental health issues in the workplace (8)
- Addressing the problem and facilitating a solution (7)

- Sense of relief for the employee expressing mental health problems (6)
- Getting treatment faster (5)
- Manager is stimulated to make decisions (3)
- Creating an open work context (2)
- Better work life balance (1)

8.2.5.2 Needed activities to reduce stigma

Needed activities to reduce stigma	To a large extent (4)	Some-what (3)	To a small extent (2)	Not at all (1)	Don't know	M (IQR)
Printed materials about mental health	16 25.8%	16 25.8%	20 32.3%	7 11.3%	2 3.2%	3 (2)
Online information materials about mental health	23 37.1%	17 27.4%	13 21%	6 9.7%	2 3.2%	3 (2)
Counselling provided or funded by work	32 51.6%	16 25.8%	6 9.7%	4 6.5%	2 3.2%	4 (1)
Awareness campaigns	33 53.2%	15 24.2%	8 12.9%	4 6.5%	1 1.6%	4 (1)
Workshops on mental health given by a professional	25 40.3%	22 35.5%	9 14.5%	3 4.8%	2 3.2%	3 (1)
Workshops on mental health given by an expert-through-experience	33 53.2%	16 25.8%	7 11.3%	4 6.5%	1 1.6%	4 (1)
Website about how to reduce stigma in the workplace	22 35.5%	12 19.4%	15 24.2%	10 16.1%	2 3.2%	3 (2)
E-mail or chat options to discuss stigma	18 29%	16 25.8%	15 24.2%	9 14.5%	0 0%	3 (2)

Other tools that workplaces need to reduce stigma towards mental health problems:

- Creating a culture where mental health issues can be openly discussed (1)
- Identification of environmental determinants of mental health related to working and employment (1)
- Implementation of action protocols by supervisors and managers (1)
- Inclusive leadership (1)

- Training in the workplace (1)
- Material from Workers' Unions (1)
- Broader workshops about mental health (not limited to mental disorders and stigma) (1)

8.2.5.3 Acceptability of anti-stigma interventions

Degree to which managers would agree with following statements about anti-stigma programs	To a large extent (4)	Some-what (3)	To a small extent (2)	Not at all (1)	Don't know	M (IQR)
Anti-stigma programs have a positive impact	21 33.9%	25 40.3%	14 22.6%	0 0%	2 3.2%	3 (1)
Anti-stigma programs can increase wellbeing	21 33.9%	24 38.7%	13 21%	1 1.6%	3 4.8%	3 (1)
Anti-stigma programs can increase productivity	22 35.5%	21 33.9%	13 21%	3 4.8%	3 4.8%	3 (2)

Main barriers when conducting mental health anti-stigma activities:

- Shame based on stigma (11)
- Lack of knowledge (11)
- Thinking that such activities are not relevant (5)
- Lack of time (4)
- Organizational culture (3)
- Denying or actively avoiding the subject (3)
- Lack of trust in potential benefits (2)
- Lack of funding (2)
- Indifference/Lack of will to conduct mental health anti-stigma activities (2)
- Lack of support by managers (2)
- Conflicting differences (2)

List of anti-stigma programs commented by experts:

- 'I AM WHOLE'-campaign: https://www.whole.org.uk/
- 'Accenture Allies Programmme': https://www.accenture.com/gb-en/company-accenture-allies-programmes
- Mielekäs työ by Mielenterveyspooli (translation: Mental Health Pool): https://mielenterveyspooli.fi/
- Hyvän mielen työpaikka (translation: Brain Work): https://www.ttl.fi/oppimateriaalit/en/
- MATES in Construction: https://mates.org.au/

- Samen Sterk zonder Stigma (translation: Strong Together without Stigma): https://www.samensterkzonderstigma.nl/
- Per la Salut Mental, dóna la cara by Obertament: https://obertament.org/ca
- See change by Green Ribbon: https://seechange.ie/green-ribbon/
- 'Health Day': https://www.who.int/westernpacific/news/events/world-health-day
- 'World Mental Health Day'
- 'World Suicide Prevention Day'
- Finnish Institute for Occupational Health
- German Depression Foundation
- DIXIT TV: https://dixit.gencat.cat/en/01dixit/01que_es/
- Confederación Salud Mental España: consaludmental.org
- Anti-stigma programs for people with HIV and drug abusers

8.2.6 Gender-specific needs

Gender difference in terms of help-seeking behaviours related to mental health issues:

- There is a huge gender difference in terms of help-seeking behaviour: females are more likely to ask for help and seek help sooner, whereas males are less likely to seek and allow help (22)
- There is no gender difference (9)
- Females are more likely to talk openly about mental health at the workplace whereas males don't (5)
- For men it is less cultural accepted to seek help, whereas for women the threshold to seek help is lower (3)
- Gender differences differ from setting to setting: men working in male dominated settings (blue collar jobs, construction) are less likely to seek help than men working in health care (2)
- Men tend to hide their problems and solve their problem themselves (2)
- Especially older males are reluctant to seek help (1)
- Gender differences are reducing over time (1)
- Members of the LGBT have the highest threshold to seek help (1)
- Mental health issues are more serious in men (e.g., psychotic illness) requiring hospital treatment without previous treatment (1)
- Perhaps there are differences on their gender roles within their families (1)
- There are more gender differences in the countryside than in big cities: in big cities men are more likely to be open about their problems (1)

Gender-specific aspects that should be considered when supporting an employee's mental health:

- Gender-specific aspects should be considered when supporting an employee's mental health (17)
- Mental health support is important for everyone regardless of gender, so there shouldn't be gender differences (10)
- Men commit suicide more often whereas women attempt suicide more often (3)

- Men should be guided on how to ask and seek for help (3)
- Gender inequalities in employment, working conditions, and work life balance are important to consider; both genders need to be treated equally (2)
- Women require more commitment (1)
- Women experience a lot of pressure at home (1)
- Women may have depression due to hormones (e.g., postpartum depression or menopause) (1)
- Gambling is more common in men (1)
- It's important to focus on other more specific target groups: parents of young children, older men, LGBT, etc. (1)
- In Albanian workplaces, employees stick to gender roles and men and women socialise separately (1)
- Materials are perhaps more suitable for women and used more often by them (1)
- Men and LGBT need more discretion (1)
- Needs differ between work sectors (1)
- Peer support and relying on mental health champions are especially important to convince men (1)
- Support for men should be written in male language so that men with a traditional masculine identify are reached (1)
- Support in men should focus on tackling the misconception the mental health issues refer to weakness and a lack of strength (1)
- Seeking help does not denote weakness but rather recognition of the problem (1)
- Support in men should focus on opening up about mental health issues (1)
- Support in men should focus on recognizing a psychological problem (1)
- Gender neutrality should be used in all support and communication (1)
- Women report more depression, anxiety, burnout and stress (1)
- Women more often work in settings with client and patient contact; in these settings there are more absences from work due to mental health issues (1)

Specific aspects that need to be considered in male dominated workplaces and female dominated workplaces in terms of creating a mentally healthy workplace:

- Specific needs should be considered in male/female dominated workplaces (23)
- Support should not focus on gender specific needs but on making workplaces better in general; everyone needs help (4)
- Female employees that take care for family and kids should receive additional (financial) support and attention (2)
- In male dominated workplaces stigmatising attitudes towards females and specific needs of females should be targeted (2)
- In male dominated workplaces, stigma and hiding problems should be targeted (2)
- Tackle abuse from managers and irresponsible colleagues (1)
- Within male or female dominated workplaces there can be differences in needs also (1)

- Certain problems are more likely to arise in either male or female dominated workplaces (1)
- Different language should be used in support for males (1)
- Female dominated workplaces should consider inequality in terms of wages, work overload, household responsibilities (1)
- Women face more daily life challenges (1)
- Female dominated workplaces should consider the marital status, the economic situation, and the hormonal influences in women (e.g., menopause) (1)
- Females are better in helping others (1)
- It's important to step aside from feminine and masculine roles and to consider the needs of people regardless of gender (1)
- Male dominated workplaces should focus in particular on help-seeking behaviour (1)
- Males have poorer communication skills (1)
- Those in minority (e.g., LBGT who might feel discriminated) should receive support to feel accepted and welcome in the community (1)
- Women are more emotion-focused, males are more task-focused, these aspects can be considered separately and then combined (1)

8.2.7 Acceptability of workplace-based interventions

8.2.7.1 Acceptability for managers/supervisors

Possible concerns of managers related to implementing mental health interventions	To a large extent (4)	Some-what (3)	To a small extent (2)	Not at all (1)	Don't know	M (IQR)
Workplace is not responsible for employees' mental health	22 35.5%	25 40.3%	10 16.1%	4 6.5%	1 1.6%	3 (1)
Staff will hesitate to participate in interventions in the workplace	18 29%	33 53.2%	7 11.3%	2 3.2%	2 3.2 %	3 (1)
Lack of resources for implementation	33 53.2%	21 33.9%	6 9.7%	1 1.6%	0 0%	4 (1)
Employees will access interventions during work time or using work resources	32 51.6%	19 30.6%	8 12.9%	0 0%	2 3.2%	4 (1)
Workplace is not an appropriate setting for such interventions	17 27.4%	34 54.8%	6 9.7%	4 6.5%	0 0%	3 (1)

Other concerns that managers might have when it comes to implementing mental health interventions in the workplace:

- Concerns about a reduction in performance (3)
- Lack of knowledge about mental health (2)
- Workload for supervisors (1)
- Uncertainty about the responsibilities of the workplace (2)

The extent to which the following topics may influence managers in deciding whether or not to implement interventions in the workplace	To a large extent (4)	Some-what (3)	To a small extent (2)	Not at all (1)	Don't know	M (IQR)
Information on the economic benefits	41 66.1%	13 21%	4 6.5%	2 3.2%	1 1.6%	4 (1)
Information on the social benefits	23 37.1%	21 33.9%	14 22.6%	1 1.6%	1 1.6%	3 (2)
Testimonials from managers who have implemented mental health interventions	37 59.7%	14 22.6%	6 9.7%	0 0%	4 6.5%	4 (1)
Scientific information on the benefits of an intervention	16 25.8%	25 40.3%	13 21%	4 6.5%	3 4.8%	3 (2)
Simple implementation that requires minimal manager/HR time	30 48.4%	23 37.1%	6 9.7%	1 1.6%	1 1.6%	3,5 (1)
Simple implementation that requires minimal employee time	27 43.5%	26 41.9%	4 6.5%	2 3.2%	2 3.2%	3 (1)
Relevance to COVID-19 pandemic	16 25.8%	24 38.7%	15 24.2%	3 4.8%	3 4.8%	3 (2)

Other topics that may influence managers or supervisors when deciding whether or not to implement mental health interventions in the workplace:

- Clear boundaries and demarcated responsibilities (2)
- Economic incentives (1)

8.2.7.2 Acceptability for employees

Issues that may prevent employees from participating in mental health interventions	To a large extent (4)	Some-what (3)	To a small extent (2)	Not at all (1)	Don't know	M (IQR)
Confidentiality	43 69.4%	16 25.8%	2 3.2%	0 0%	1 1.6%	4 (1)
Discrimination or stigma	43 69.4%	16 25.8%	3 4.8%	0 0%	0 0%	4 (1)
Career progression or job security	43 69.4%	12 19.4%	6 9.7%	0 0%	0 0%	4 (1)
Workplace should not get involved with employees' mental health problems	16 25.8%	31 50%	10 16.1%	3 4.8%	0 0%	3 (1)

Other issues that may prevent an employee from participating in mental health interventions:

- Fear of the unknown and lack of trust (2)
- Mental health interventions are led by incompetent persons (1)

8.2.7.3 Acceptability of online tools aimed at individual employees

Acceptability of online tools aimed at individual employees	Strongly agree (5)	Agree (4)	Neutral (3)	Disagree (2)	Strongly disagree (1)	M (IQR)
Uncomfortable to access while being at work	15 24.2%	29 46.8%	9 14.5%	7 11.3%	2 3.2%	3 (2)
Accessing online intervention while being at work might have negative repercussions	9 14.5%	18 29%	14 22.6%	17 27.4%	4 6.5%	2 (2)
Accessing online intervention while being at work might have negative repercussions for the employers/business/SME	5 8.1%	13 21%	21 33.9%	15 24.2%	8 12.9%	2 (2)

Employees have easy access to a computer during working hours	15 24.2%	20 32.3%	19 30.6%	6 9.7%	2 3.2%	3 (2)
Employees have more easy access to a smartphone	20 32.3%	23 37.1%	15 24.2%	4 6.5%	0 0%	3 (2)

8.2.8 Additional comments

- Other needs concerning mental health in the workplace
    - More focus on mental health promotion is desirable (1)
    - More focus on alcohol and drug dependency is desirable (1)
    - Occupational medicine is desirable (1)
    - More information, on-site and online trainings, websites, and conferences are needed about LGBTQI+ employees (1)
    - Promote training in detection and involvement of senior (older generations) positions, where knowledge about mental health is less present compared to younger generations (1)
- Current problems concerning mental health
    - A large taboo concerning the mental state of employees exists (1)
    - A deep lack of knowledge and of concern about mental illness exists (1)
    - Time to take care for people decreases, because administrative tasks increase (1)
    - There are insufficient personnel to focus on tasks related to mental health in the workplace (1)
- Other programs/initiatives that exist, concerning mental health in the organizational setting
    - The occupational doctor/organizational psychologist addressing mental health issues in employees (1)
- Role of certain organizational structures on mental health (e.g., matrix organization)
    - There is a positive effect of project and matrix organizations on well-being (1)
    - Workers' mental health is strongly related to employment and working conditions. Interventions should take place at the organizational level, not at the individual level only (1)
- IT sector
    - Tremendous pressure to deliver with little room for error, even though error is inevitable. Preparing employees and providing them with tools and mechanisms to deal with these situations can increase employee’s mental health (1)

Appendix 5

28 July 2020 TC, 8.00 – 8.30 CET

Expert Meeting #1

MINUTES

Attendees: Ella Arensman, Gyorgy Purebl, Nicola Reavley

Ella welcomed the group and thanked Nicola for her availability. The discussion would be based around:

- the stigma evaluation measure
- the MENTUPP anti-stigma materials

The stigma evaluation measure

The concept of stigma that MENTUPP would like to approach is discrimination / inequality and equality in relation to mental health. The current stigma evaluation measure has 42 items which seems long and we would like to bring down the number of items.

Nicola thought this measure was very long. She stated that we need to move away from asking people their attitudes of mental health and ask them about their experiences. She thought this could be done in one (open-ended) question which would then need coding. This has been done in a national survey sample in Australia and Nicola would be happy to send that to Gyorgy.

Gyorgy agreed that this would be very helpful and it could be mentioned that this question was already used in a large-scale survey in Australia and that the results were published. Nicola will send the relevant papers to Gyorgy and Ella. Ella agreed that it would be very helpful for MENTUPP publications to say that this question has been used and validated. It is also complementary to the depression stigma scale re attitudes and behavior.

Action point: Nicola to send some papers re the national survey sample as above.

The MENTUPP anti-stigma materials

Gyorgy's team are currently working on an anti-stigma video. He will send the footage to Nicola in the next week. It is a cartoon/animation video which will be complementary to the peer-support videos being produced by WP2. It will contain brief stories about a person in a workplace with a focus on communication of mental health videos.

Action point: Gyorgy to send footage of the anti-stigma to video to Nicola for her thoughts when available.

Ella mentioned that in a recent presentation to construction workers that she discovered approximately one-third could not read well. Therefore, MENTUPP needs different types of materials which may appeal more, including visual and animation. Nicola agreed that each sector needs to see people from their sector in the material.

The Delphi survey will happen in August. Nicola mentioned that the Delphi survey they did made up the content of their Mental Health First Aid course. She will send on some further papers on their Delphi survey.

Action point: Nicola to send Delphi survey papers to Ella for circulation to the MENTUPP team.

Ella told Nicola about the publication sub-committee for MENTUPP that will meet in late August and that the team would be happy for Nicola to contribute to this. Nicola would be happy to make a contribution where she can.

Action point: Ella to keep Nicola informed of the Publication Sub-Committee.

Ella thanked Gyorgy and Nicola for participating in this meeting.