



Inuka Coaching presents

Event: understanding **evidence of effectiveness** for **well-being** programmes, to support scaling

How do you know if a well-being program is effective? How would effectiveness be measured? Which roles are critical for discussions on scaled implementation and how would an ROI case be constructed?

November 17th, 4-5pm CET (in English)

Hosted by: **Anoushka Bold**, researcher @ VU and Inuka

Audience: All involved in decision making on Well-being programs



Aim of today:

Share research results & practical insights for well-being decision makers



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Inuka's Purpose

Everyone resilient

Inuka's mission is to make wellbeing accessible for everyone and sharing how is part of our mission

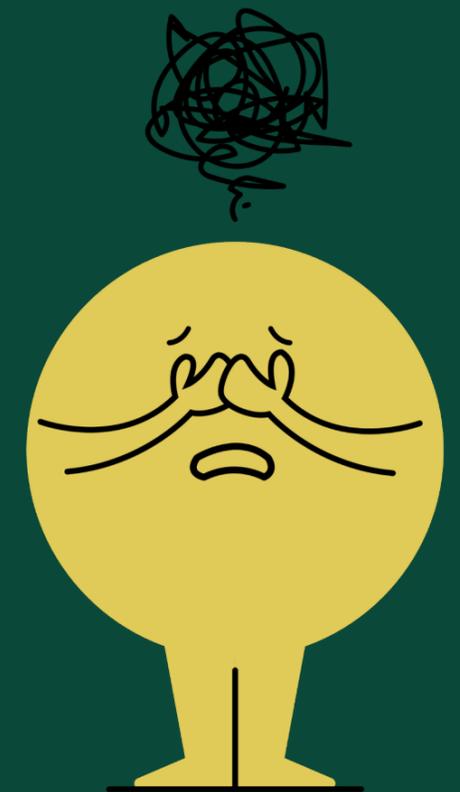


What we'll talk about today

- Background on stress in the workplace
- Research focus and approach
- **Research results**
- **Key take-outs and practical resources**
- Questions and dialogue

Introduction

Work-related stress is the # 1 cause of sick absence, drop-out and burn-out



Work-related stress is a significant and growing issue

44.6% EU workers report facing MH risk factors

51% of UK employee ill health is due to CMDs
55% of UK working days lost due to CMDs

16% of NL workers with burnout complaints

9.4m NL working days lost due to work-stress

€9,300

Average per employee cost of work-related absenteeism (TNO)

€19,151 / € 30,770

Average per episode cost of stress-related ill health / burnout

Definitions of key terms

Work-related stress

A harmful reaction people have to undue pressures and demands placed on them at work,
(HSE, 2020)

Stakeholders

Actors who have an interest in the issue under consideration, who are affected by the issue, or who have an active or passive influence on the decision-making and implementation processes'
(Varvasovszky, 2000)



The employer and human costs are significant

Employers

- 70-100% of salary for up to 2 years
 - €3.2 billion per year, €9,300 per employee (TNO, 2020)
 - €19,151 cost of stress-related ill health / €30,770 cost of burnout (Wolvetang, 2022)
- Loss of productivity from absence / burnout, high unplanned attrition,
 - Impact to business continuity, cost of backfill and new hires
 - Impact to employer brand. Difficulty to attract talent
 - Legal compliance – ISO 45003
 - Reduced capacity for innovation and change

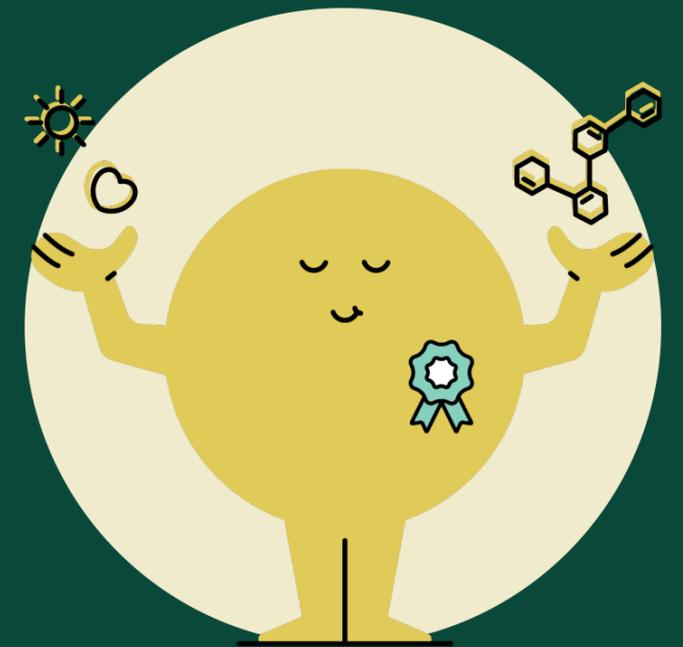
Individuals

- 44.6 % EU workers facing mental health risks
 - 1.2 million or 16% workers with burnout complaints
- Personal suffering
 - risk of social isolation
 - Stigmatisation
 - long-term sick leave
 - threat to personal income

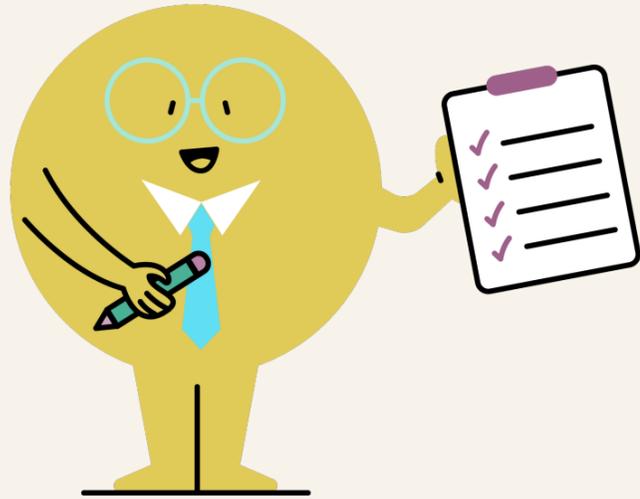
'Given all that is already known on mental wellbeing and the strong incentives for employers and other stakeholders to implement effective solutions, it is perhaps surprising that workplace stress and wellbeing is worsening and not improving.'



Research focus and approach



Research Study Question



Research Question

- How to generate credible evidence of effectiveness of mental health workplace interventions, to support scaling of solutions?

By Understanding..

- What does connected research tell us?
- How are interventions proven effective via research?
- Who is **funding** this type of research?
- How are **return on investment** cases made?
- Who are the **key stakeholders** and **what are their interests?**
- What are key **stakeholders' views of strong evidence?** How do they make decisions?

3 methods to collect data, over 8 months

METHOD 1

Literature Review

3,119 records reviewed
463 abstracts reviewed
22 articles included

METHOD 2

Online survey for key stakeholders

38 responses

METHOD 3

Semi-structured interviews with key stakeholders

11 interviews



Ministry of Defence



Amsterdam UMC
Universitair Medische Centra

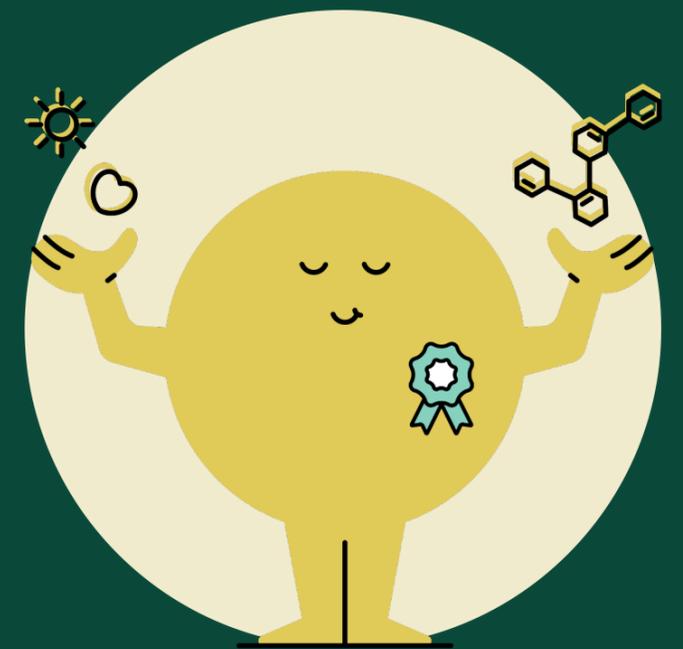


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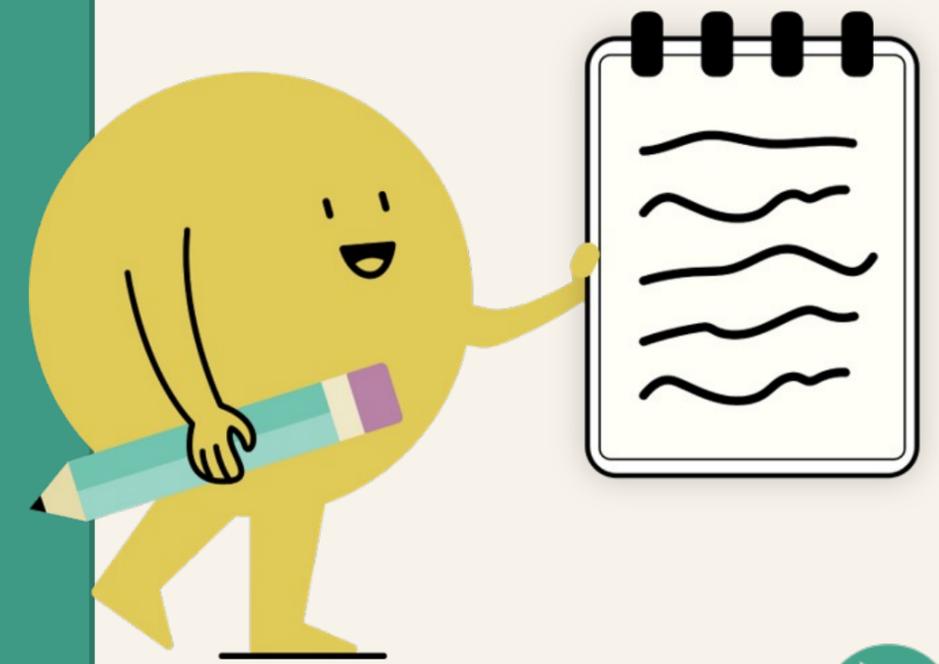
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Research results



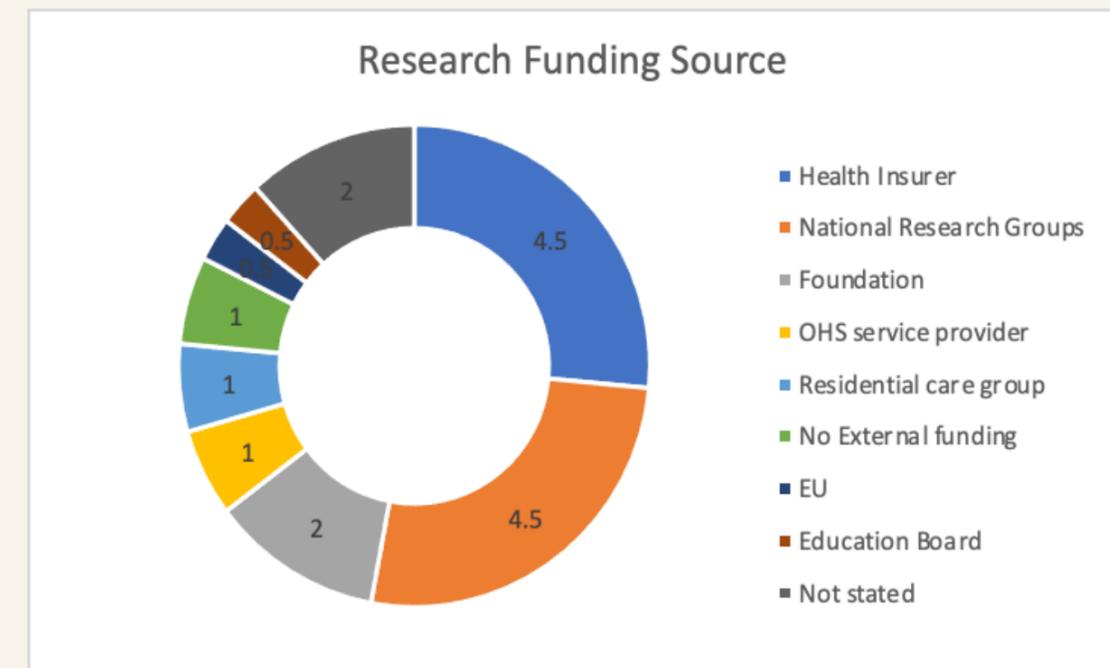
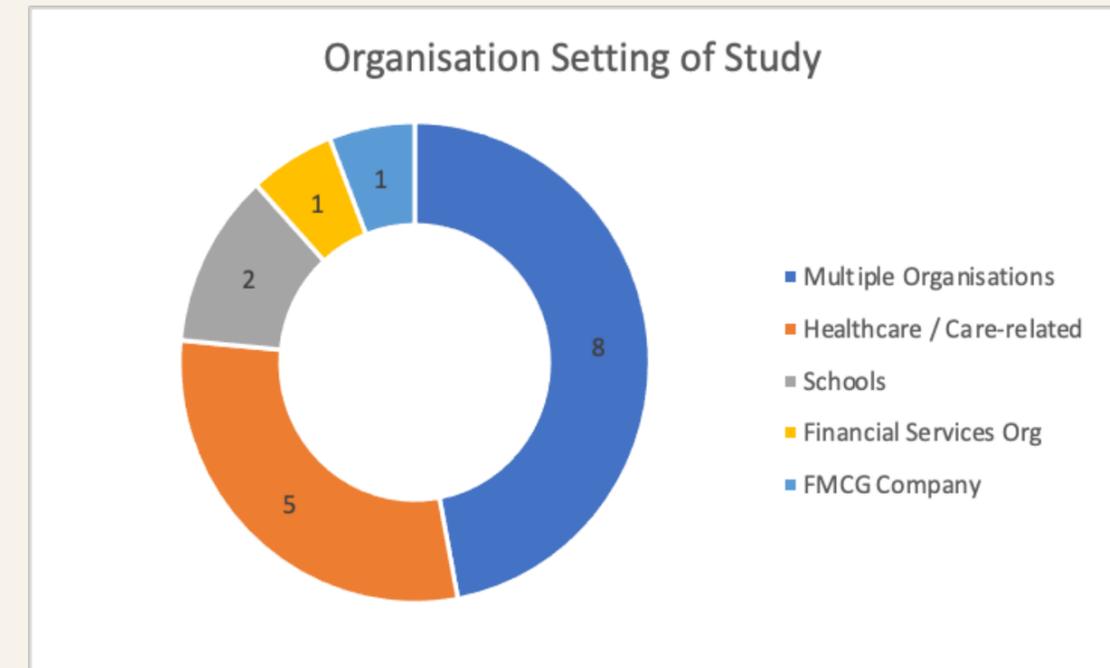
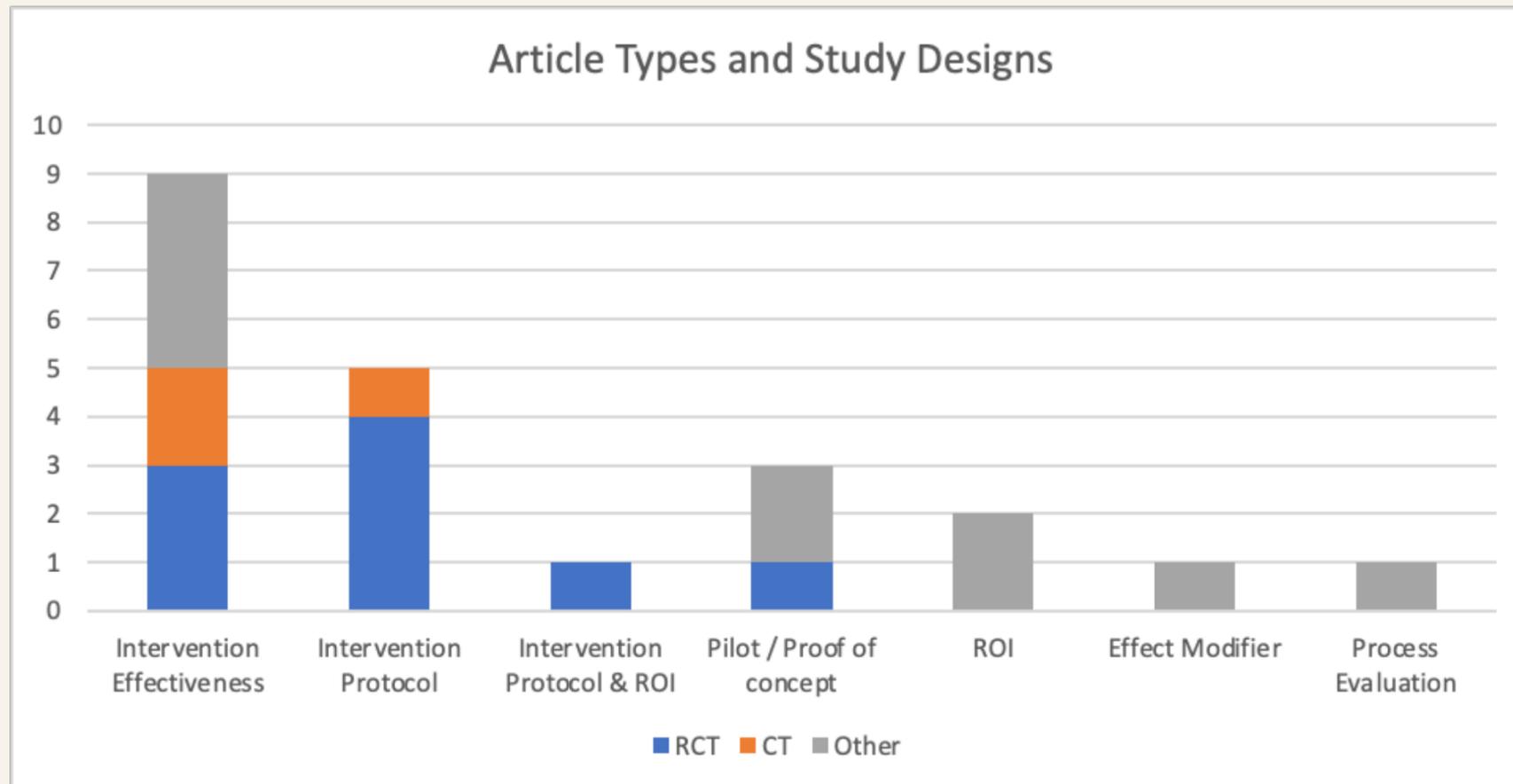
Topics that are being researched

- Relatively active field: 463 studies in 5 years
- Only 17 studies/22 papers on intervention effectiveness
- Research focus on burnout / return to work (n=80)
- Predominant healthcare setting (n=50)
- Determinants of burnout (n=30)
- 'Job demands – resources theory' of Demerouti et al (n=50)
- Org culture/ leadership (n=28)
- COVID (n=17), prevention (n=16), vitality management (n=12), workaholism (n=12), sustainable employment (n=10)



Intervention Effectiveness Studies (17 studies, 22 articles)

- Pilots and protocols show that more is to come
- Nearly 50% of studies are across multiple organisations
- Health Insurers fund ¼ of the research
- Research groups fund ¼ of the research
- Organisational decision makers are not funding research



Intervention effectiveness studies (average)

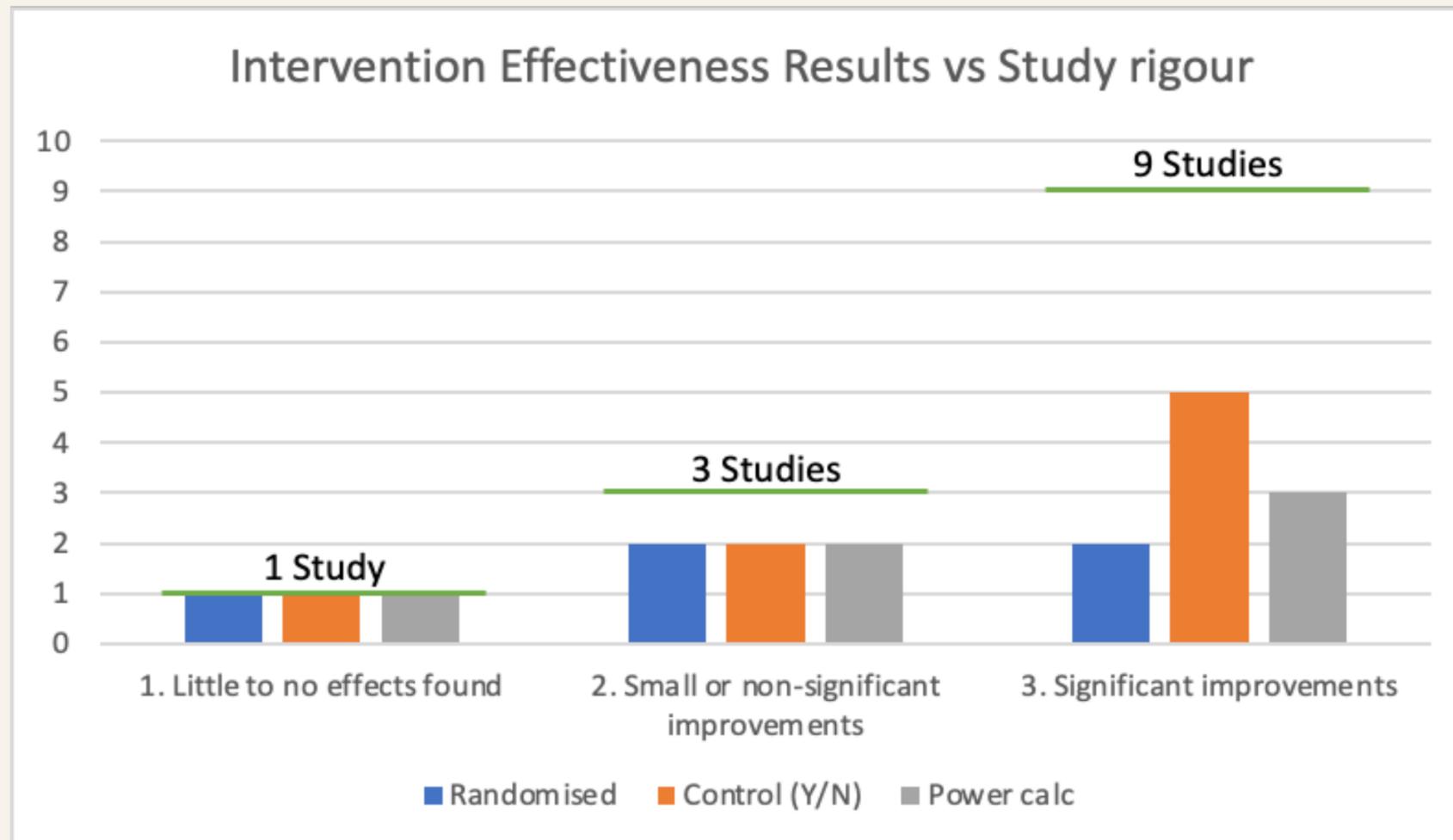
Average study

- Intervention of 2-3 months
- ~ 220 participants
- Measurements at baseline, 6 months, and 1 year
- Underlying theories; psychosocial education, emotion regulation, Problem solving therapy, cognitive behavioural therapy, physical activity, mindfulness, positive psychology
- Randomised control trials, or at least a control trial

Key success factors

- Involvement of leadership
- Resources made available to participate in work hours

What are the results? What works?



Underlying mechanism for Significant Improvements

- Psychoeducation
- Problem solving therapy
- Cognitive behavioural stress management
- Emotion regulation
- Personal development coaching
- Stress screening then matching to relevant support/intervention
- Positive management techniques
- Mindfulness
- Physical exercise

Little / no effect – psychoeducation and online games combined

How are results measured?

Measurement Tool	Incidence
DASS-21 - Depression, Anxiety and stress scale	9
ISI (Insomnia severity Index)	5
MBI-GS (Maslach-Burnout-Inventory)	8
PSC (Psychosocial Safety Climate)	5
PSS-10 (Perceived Stress)	7
TiC-P (Utilisation of Health services and Work-related productivity)	6
UWES (Utrecht Work Engagement scale)	8
WAI-SR / WAI-SRT (Working Ability Index)	5

Clear space between how research measures results (clinical) and organisations (operational)

Type of Metric	#	Key Stakeholder Mentions
1/ Cultural Health Indicators		
Engagement / wellbeing Pulse Score	5	0301HRD, 0501WEL, 0901HRD, 1102DIR, 0802WEL
Net Promoter Score	1	0301HRD
D&I Score	1	0701INS
Attendance to drinks and seasonal parties	1	0101ADV
Year-end reviews completed on time	1	0101ADV
2/Sickness dynamics		
Short, mid and long term sickness leave	5	0301HRD, 0501WEL, 0901HRD, 1102DIR, 0802WEL
Cost of sickness leave	1	0301HRD
Health services demand	1	0701INS
3/ Attrition and recruitment dynamics		
Unplanned attrition	3	0301HRD, 0901HRD, 0101ADV
Unplanned attrition of new joiners	1	0101ADV
Time to fill	2	0301HRD, 0101ADV
Ability to recruit top talent	1	0101ADV
4/ Intervention rating		
Intervention demand	1	0701INS
Intervention rating	1	1001HRD
Sickness after intervention	1	1001HRD
Intervention implementation time	1	0301HRD
Employees talking about vitality	1	0301HRD

How are ROI Cases made?

Research: Cumulative direct costs of the intervention and intervention management, vs the cost of presenteeism and absence, using real or average salary data, compared to control.

- Wijnen, 2020: 1 year payback with 96.7% likelihood
 - Up to €3,000 of intervention cost per person to break even
 - Testing ROI of a process to diagnose challenges and match interventions
- Van Dongen, 2017: Negative ROI
 - Testing 2 specific interventions, not previously proven to be effective

Practise:

- ROI cases expected to be useful but are currently not often made
- No ROI case is a limiting factor for scaled implementation
- Lack of maturity in data management
- HR need support to make an ROI

Who are key stakeholders? What are their interests?

High Power, High Interest (Promoters)

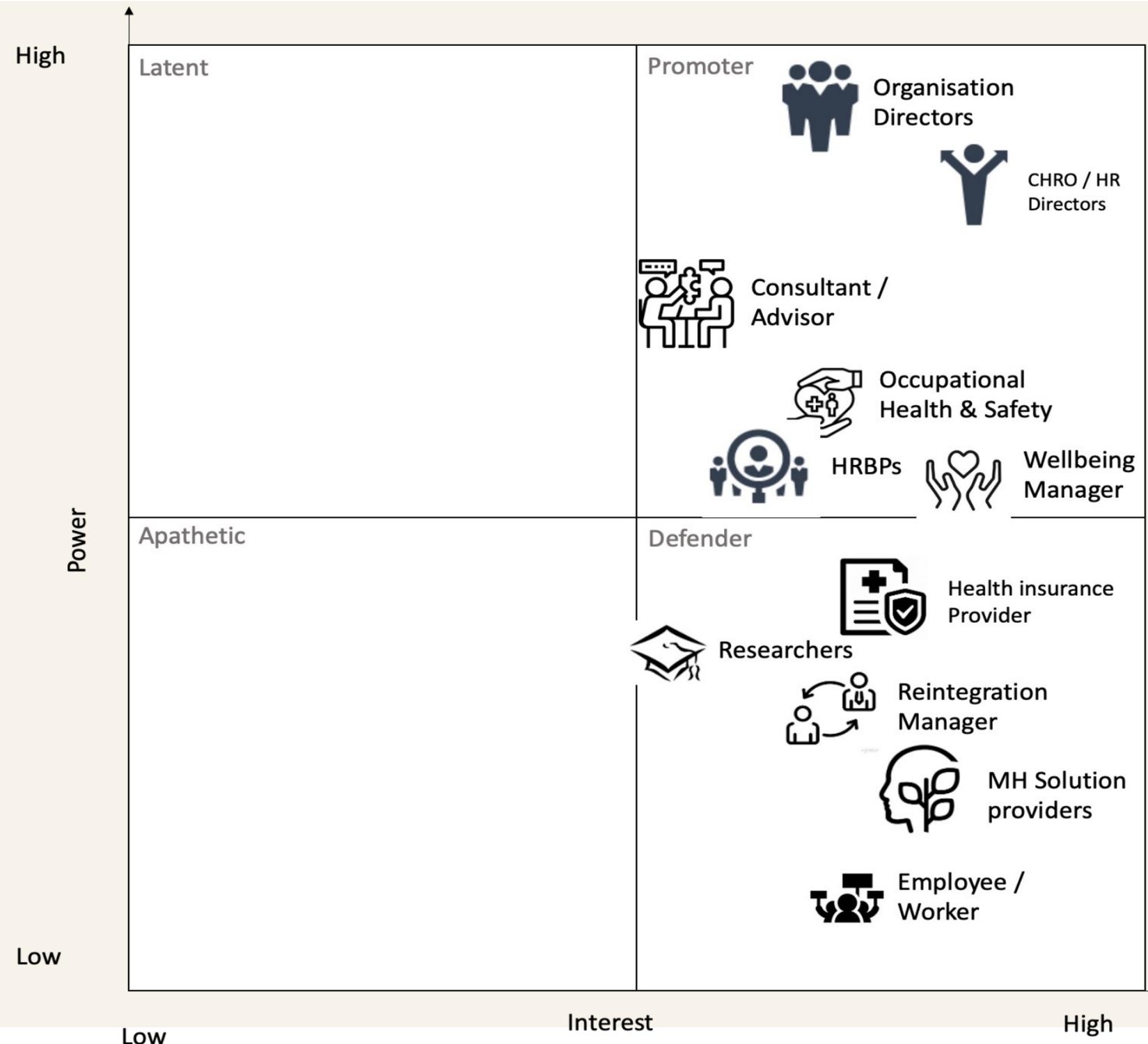
- Org Directors, CHROs
- Potential for unilateral decision making

Med Power, High-Med Interest (Promoters)

- Consultants, OHS Leads, HRBPs, Wellbeing Managers
- Decide on pilots, or select providers within budget. Introductory roles for scaling
- Medium power, tactical operators

Med-Low Power, High-Med Interest (Defenders)

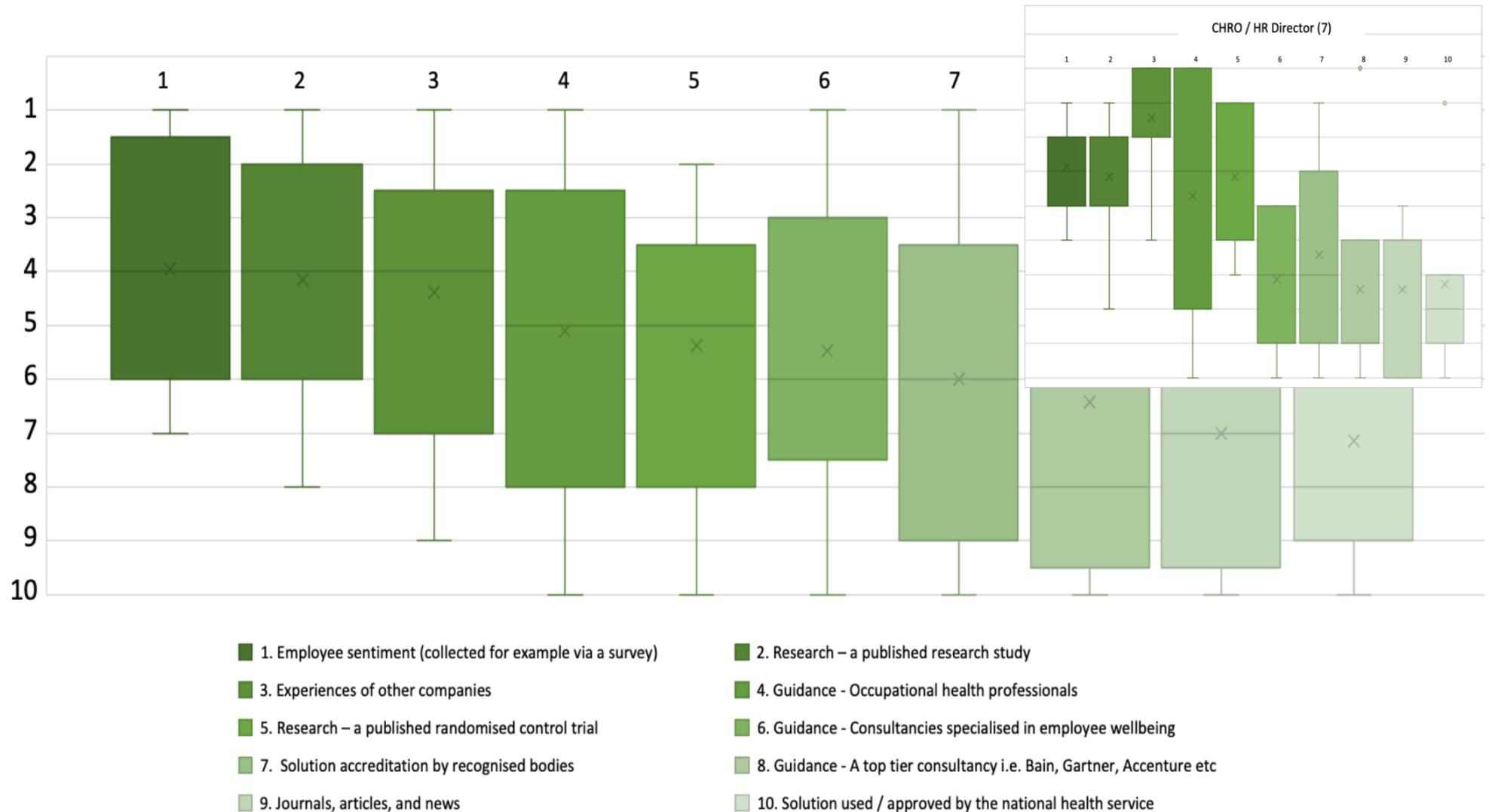
- Health Insurance providers, Researchers, Reintegration managers, MH solution providers, Employees



Stakeholders' view on strong evidence?

1. Experience of other companies
2. Published research studies
3. Employee sentiment?
4. Guidance from an OHS professional

Figure 9: Survey, priority of evidence of effectiveness of employee wellbeing solutions



Stakeholders' Decision Making Criteria – Why?

Multiple reasons are relevant:

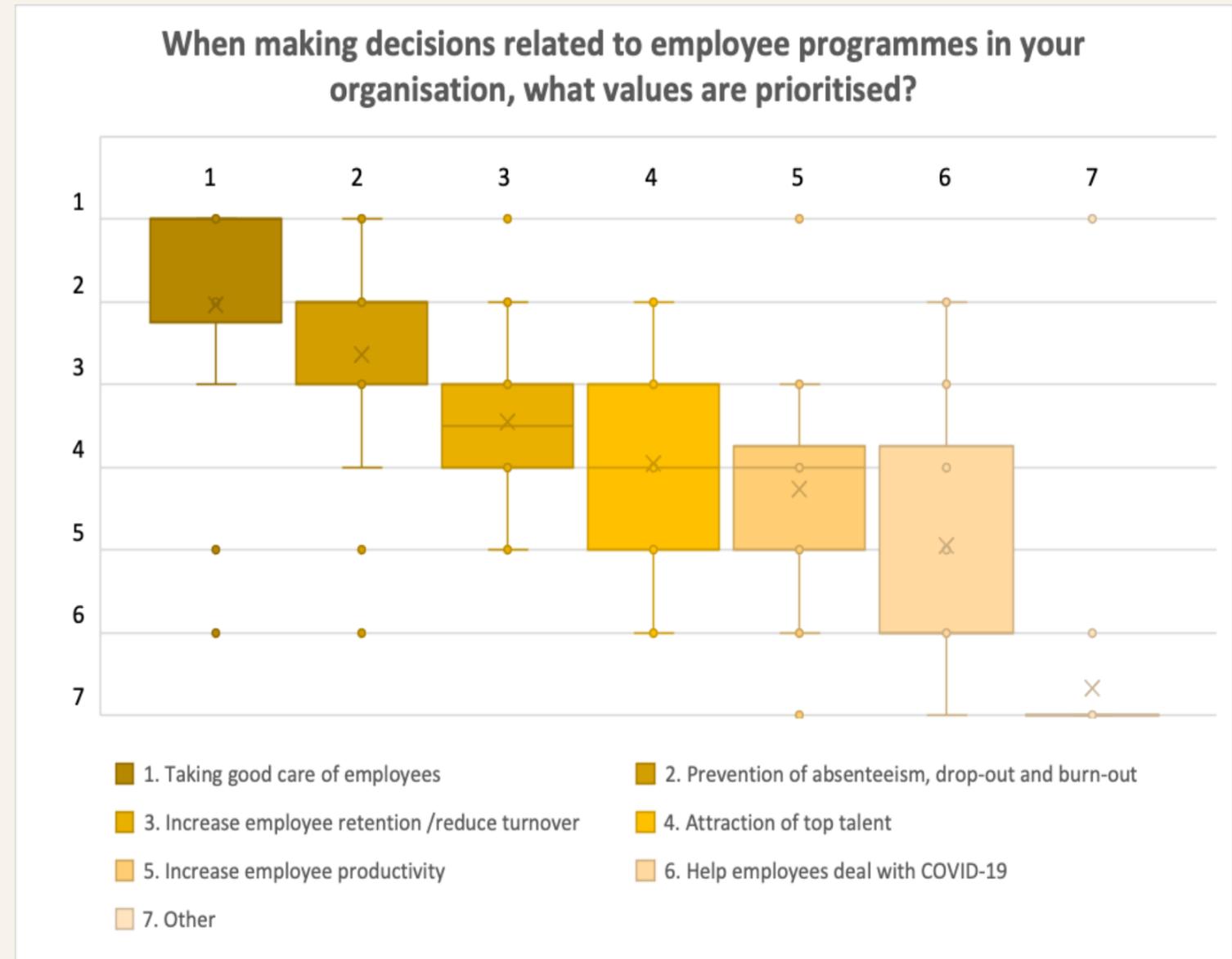
1. Taking good care of employees

2. Prevention of absenteeism, drop out, burn out

3. Increase employee retention / reduce turnover

4. Attraction of top talent

* Ability to manage business change



Stakeholders' Decision Making Criteria – How?

Nebulous, vague and ill-defined, with considerable variability

- Governance shows a lack of maturity
- Not always clear who is involved in the decision or not
- Decision making varies both between and within organisations
- Potential role involvement: Company Director, HR Director, HRBP, Wellbeing Lead, OHS Lead, Consultants, Health Insurance providers, Works Councils and employees
- Sometimes decisions are taken unilaterally by CEO / CHRO

Stakeholders' Decision Making Criteria – What?

#	Criteria	Mentions	Count
1	Reputation / Positive employer referral	0701INS, 0301HRD, 0901HRD, 1001HRD, 0802WEL, 0602OHS	6
2	Cost	0301HRD, 0402DIR, 0602OHS, 1001HRD, 0802WEL	5
3	Ease / time for implementation	0301HRD, 0402DIR, 1001HRD	3
4	Accessible / simple to use	0402DIR, 0602OHS, 1001HRD	3
5	Customer orientation/ values / gut feel	0901HRD, 1001HRD, 0802WEL	3
6	Appropriate - solve the need / same MH vision / inspiring	1001HRD, 0802WEL, 0701INS	3
7	Quality / Evidence of effectiveness	0701INS, 1001HRD	2
8	Absenteeism / Attrition	0301HRD, 0901HRD	2
9	Security and data integrity	1001HRD, 0802WEL	2
10	Size and capacity of organisation	0901HRD	1
11	Native english speakers	1001HRD	1

- Decision making criteria seemed not to be pre-determined
- Multiple criteria considered

4 Emerging themes

1/ Nebulous and idiosyncratic decision making

2/ Strategic, holistic, collaborative

3/ Gap between research and practice

4/ Impact and ROI to enable scale



Strengths, Limitations and Conclusion

Strengths:

- Somewhat unique in bridging research and practise
- 3 separate methods for data triangulation

Limitations:

- Small survey sample size is descriptive and not representative
- Rapid research techniques used due to time and resource availability

Conclusion

- Not one but multiple approaches to generate credible evidence of effectiveness for scaling
- Involvement of decision makers is critical
- Further research to build effectiveness evidence should be transdisciplinary

Key take-outs and practical resources



- ❑ MH Intervention research in the workplace is a new and growing area
- ❑ Successful interventions use known and proven underlying theories
- ❑ Intervention success factors;
 - Involvement of leadership
 - Resources made available to participate in work hours
- ❑ Results and impact can be measured and should be
- ❑ ROI cases are needed for scaled impact, and the investment case is easy to make
- ❑ Key decision makers are CEO/Directors and CHROs / HR Directors
- ❑ Key reasons to invest in Well-being are: To care for employees, to prevent absenteeism drop out and burnout, increase employee retention, and to attract top talent

- Does the provider use an underlying method that is known to be effective?
- How is impact measured and what results have others achieved with this solution?
- Is there research proving effectiveness of the provider's solution?
- Is the cost reasonable and does it incentivise both parties?
- How much effort is the solution to implement?
- Is the solution accessible for employees?
- Do you vibe on values? Do they understand you? Do they care about your outcomes?
- Does the solution solve your need?

4-step roadmap which considers:

- **Absenteeism**
- **Burnout**
- **Presenteeism / Languishing**
- **Top Talent Attraction**
- **Innovation Capacity**
- **Business Transformation**

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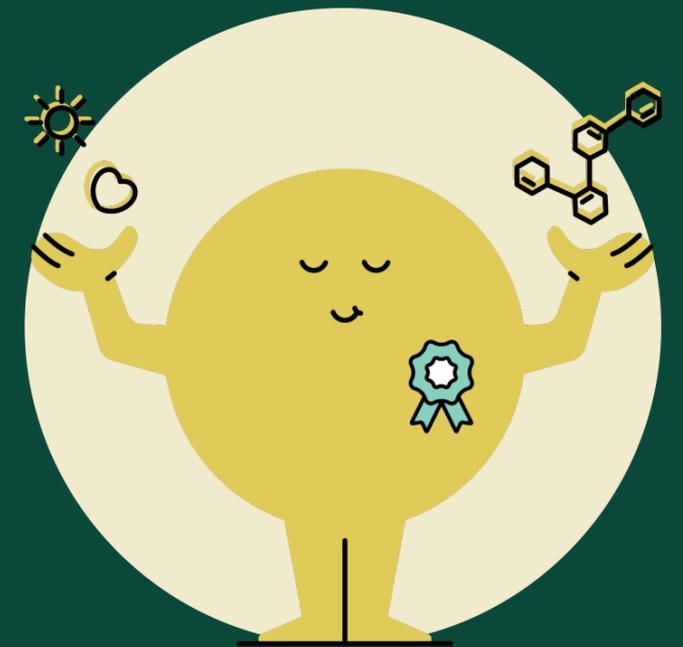


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Questions and Dialogue



Thank you.
Enjoy your day.

