A pilot study assessing the feasibility, usability and effectiveness of a new online mental health training program for workplace managers.

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Abstract

**Background:** Mental health has become the leading cause of sickness absence in high-income countries. Managers can play an important role in establishing mentally healthy workplaces and in coordinating their organisation’s response to a mentally ill worker.

**Objective:** This pilot study evaluates the feasibility, usability, and likely effectiveness of a newly developed online training program for managers called HeadCoach. HeadCoach aims to build managers’ confidence in supporting mental health needs of staff and promote managerial behaviour most likely to result in a more mentally healthy workplace.

**Methods:** Sixty-six managers in two organisations were invited to participate in this pilot evaluation of HeadCoach. HeadCoach was available to managers to complete at their own pace over a 4-week period. Data was collected at baseline and post intervention via an online research platform. The difference in mean scores of each of the outcomes between these two time points was calculated using paired samples t-tests.

**Results:** Thirty-nine managers (59.1%) participated in the trial, with complete pre-post data available for 22 participants (56.4%). The majority of respondents reported positive engagement with the program. Over the study period managers’ knowledge regarding their role in managing mental health issues (P=0.01) and their confidence in communicating with employees regarding mental illness (P<0.001) significantly increased. There was also a significant increase from baseline in managers’ self-reported actions to employ strategies to prevent and reduce stress among their team (P =0.02).

**Conclusions:** Although caution is needed due to the absence of a control group, preliminary results from this study suggest that HeadCoach may provide a feasible, acceptable and efficient method of training managers in best workplace practices to help support the mental health needs of their staff.

**Keywords:** Manager, Supervisor training, Workplace mental health, Mental health education, Online intervention, Knowledge, Attitudes, Behaviour, eHealth
Introduction

Throughout many high-income countries, mental health conditions have become the leading cause of long-term sickness absence and incapacity in the workplace [1-4]. The development or persistence of mental ill health for some workers may, in part, be related to their workplace [5], a link that has now been acknowledged as a major public health concern [4]. Anxiety and mood disorders are the most common mental illnesses seen in the working population [6-8]. These illnesses are treatable and often preventable, however, over recent decades, rates of functional impairment due to psychiatric conditions within the working age group have increased [9]. This comes at a substantial cost to the individual, their workplace, and to the economy [4, 7, 10-14]. In response, there is a growing focus on understanding how work can impact on mental health and how it can be addressed through workplace-based mental health and well-being interventions [5, 15, 16].

Workplace mental health programs can be a chance to alter modifiable risk and protective factors for mental health and/or a chance to aid the identification, treatment and rehabilitation of workers with mental health problems. Certain psychosocial working conditions have been identified as primary sources of work-related stress, which if not managed effectively can negatively impact upon workers’ well-being and productivity. These include conflicting and excessive work demands, a lack of job control, organisational failure to effectively communicate with staff, and poor collegial relationships and support [15, 17]. Many of these workplace risk factors can be modified through decisions and adjustments which managers are often in a position to make [18]. Managers can also role model accepting behaviours and attitudes towards mental illness that can act as protective factors for their workers through the promotion of a mentally healthy working environment. In addition, managers can react to mental ill health episodes in a way that can be beneficial in the recovery process for workers [19]. Such strategies include, but are not limited to, facilitating regular conversations with an employee, maintaining a focus on employee well-being, and developing an appropriate return to work plan if a worker is on long-term sickness absence for a mental health issue, regardless of the
underlying cause [20, 21]. Despite the availability of best practice guidelines detailing these primary, secondary and tertiary approaches to managing mental health in the workplace, managers often report uncertainty in how to best support employees experiencing or at risk of mental ill health [7, 21].

In order to address these concerns, many organisations are introducing training for managers in how to reduce work-based mental health risk factors for their employees, support their recovery, and facilitate successful return to work following a period of sickness absence for mental ill health. There is some evidence to suggest the value of specialised training delivered to managers to promote understanding of the mental health needs of their workers, and to help increase managers’ confidence in discussing mental health matters with their staff [2, 3, 22-24]. Further evidence supports such manager training to shift stigmatising attitudes regarding mental illness [24-27] and to promote the implementation of positive managerial behaviours to address mental health issues within their team [22, 24, 26], with an overall positive effect for manager training found across these outcomes [28]. Yet evaluations of a selection of workplace based mental health training programs have been unable to find beneficial effects upon managers’ attitudes towards mental ill health [18] or managerial behaviours of mental health issues either reported by the managers themselves, or objectively by their direct reports [18, 29, 30]. One explanation for this disparity in outcomes may be due to the selection of components included in training. It is becoming increasingly recognised that an integrated approach is considered best practice in workplace mental health interventions [15]. An integrated approach incorporates strategies to prevent harm, promote positive mental health, and address mental health in the workplace regardless of the cause of the illness [15]. However, the integration of these key components has yet to become standard in manager training resulting in the dissemination of a series of uncoordinated educational programs.

This pilot study details the development and delivery of a comprehensive online training intervention for managers called HeadCoach. HeadCoach integrates the components identified as key to mental
health training, with the aim to build managers’ confidence and ability to best support the mental health needs of the staff they supervise. Content for this online program has been derived from two separate face-to-face programs developed for managers with a focus on the mental health of their employees [22, 31], which, when combined, encompass the recommended reactive and preventative components. It is recognised that eLearning cannot offer certain benefits face-to-face contact with an educator may have, and discussion with others participating in the course is often limited or not available. However, the modification of delivery format from face-to-face to a mobile responsive website offers a more flexible, time effective, and economical means of training a large number of staff [32]. Participants have the opportunity to schedule training around the demands of their job, and may also revisit content within a standardised learning environment, providing a greater opportunity for consolidation of course material.

The aims of this pilot study were to test the feasibility and usability of the HeadCoach program. Objective data on program engagement, matched with participants’ self-reported program rating scores and free text feedback would provide information on rates of adherence and user experience. As well as evaluating uptake of and interaction with the program, this study also aimed to examine early evidence of effectiveness of HeadCoach as a workplace mental health intervention for managers. It was hypothesised that the HeadCoach program would help improve managers’ self-reported confidence to respond to the needs of staff experiencing mental health issues and to promote their implementation of managerial techniques that would create a more mentally healthy workplace. Although results of this study would not be capable of determining the true effectiveness, due to the absence of a control group, findings from this pre-post design may provide initial understanding of participants’ responses to and acceptability of the program, and is a valuable first step in examining any impact that may be found from this type of training.
Methods

Development of intervention

The HeadCoach online training intervention [33] was developed to improve workplace mental health by providing a flexible, easily accessible, and engaging training program for managers that informed them how to best aid the mental health of their employees. This program aimed to build managers' confidence to effectively respond to the needs of employees experiencing mental health issues and to implement evidence-based managerial styles that promote a more mentally healthy workplace environment.

Previously, collaborators on this trial have conducted cluster randomised controlled trials (RCTs) of two different face-to-face manager training programs that examined these two domains (reactive and prevention) independently. The ‘RESPECT’ Manager Training Program [22] is a 4-hour training package delivered by a clinical psychologist or a consultant psychiatrist to small groups of managers which combined mental health knowledge and communication training to promote more appropriate reactive responses from managers when mental health matters arise in staff they supervise. A previous RCT of this manager training showed that it resulted in changes to managers’ confidence and reactive behaviour that lasted at least six months [34]. The second existing face-to-face program, which was more preventative in its approach, aimed to improve psychosocial working conditions within an organisation through changing managers' behaviour to best promote a mentally healthy workplace [35]. The principles within this program were based on the management competencies for preventing and reducing stress at work developed by the Health and Safety Executive in the UK [36]. HeadCoach was developed to combine the content from these two face-to-face programs and transform the material into a format compatible with online delivery. Educators, designers and IT developers with experience in creating online mental health programs were consulted for the development and appearance of the learning platform. Their primary aim was to create a functional user experience that would appeal to the target audience. This included carefully
considering aspects such as the style of language in which content would be presented in, and the visual design features selected for the branding.

Consultation groups

Meetings were held ahead of the pilot stage of the trial, with representatives from the various industries partnering on the evaluation of HeadCoach. Included were members from the organisations’ own Human Resources team, Health and Wellbeing representatives, Media and Communications as well the managers representing potential users of HeadCoach. During these sessions, participants were consulted on the relevance of the vignettes to be included in the program as well as the appropriateness of the language and style. Sections of the program were also shown to determine the feasibility and usability for different industry groups. Where appropriate, adjustments were made to content and functionality based on feedback received from the consultation groups.

HeadCoach Content

HeadCoach is a self-paced intervention that comprises three topics to be completed sequentially. Each topic contains a series of 10-minute modules featuring small sections of text, activities, short videos, and practical exercises for individuals to complete. The pilot program outline is presented in Table 1. The first topic, Common mental illnesses, introduces mental health issues commonly found in the workplace. The following topic, How to help an employee you are concerned about, outlines the signs managers can look out for to assist in identifying people within their team who may be at risk of mental health issues, discusses managerial techniques that can be implemented to support employees, and provides useful steps on how to have a conversation with employees who may be experiencing mental ill health. It also details ways to help employees stay at work if they wish or return to work faster following a period of sickness absence due to mental illness. The third and final
topic, *Minimising mental health risks in the workplace*, seeks to upskill managers with techniques useful in altering a range of workplace mental health risk factors across the individual, the team and the organisation levels [21] to create a mentally healthy workplace for their employees. This is based on observational data [21] and management standard frameworks provided by agencies such as the Health and Safety Executive in the UK [36].

*HeadCoach* was expected to take participants approximately 2.5 hours to complete, though it was designed so users could work through the content at a pace that suits their learning style and job demands across a 4-week period, with automated weekly reminders sent to prompt program adherence. The intervention was accessed online through a mobile-responsive website using a desktop, laptop, tablet, or smartphone.

**Table 1:** Course outline for pilot version of *HeadCoach*

<table>
<thead>
<tr>
<th><strong>HeadCoach Manager Training Program Outline – Pilot Version</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>Topic 1: Common Mental Illnesses</strong></td>
</tr>
<tr>
<td>Module 1: Recognising Mental Health Issues</td>
</tr>
<tr>
<td>Module 2: The Workplace and its People</td>
</tr>
<tr>
<td>Module 3: Topic Summary Exercises</td>
</tr>
<tr>
<td><strong>Topic 2: How to Help an Employee you are Concerned About</strong></td>
</tr>
<tr>
<td>Module 1: Identifying People at Risk</td>
</tr>
<tr>
<td>Module 2: Providing Support</td>
</tr>
<tr>
<td>Module 3: Having the Talk</td>
</tr>
<tr>
<td>Module 4: Facilitating Help Seeking</td>
</tr>
<tr>
<td>Module 5: Modifying Work to Help Recovery</td>
</tr>
<tr>
<td>Module 6: Returning to Work</td>
</tr>
<tr>
<td>Module 7: Topic Summary Exercises</td>
</tr>
<tr>
<td><strong>Topic 3: Minimising Mental Health Risks in the Workplace</strong></td>
</tr>
<tr>
<td>Module 1: How to be a Respectful and Responsible Manager</td>
</tr>
<tr>
<td>Module 2: Managing and Communicating Existing and Future Work</td>
</tr>
<tr>
<td>Module 3: Managing Individuals within a Team</td>
</tr>
<tr>
<td>Module 4: Managing Difficult Emotions</td>
</tr>
<tr>
<td>Module 5: Topic Summary Exercises</td>
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</table>
Study Design

This pilot study was conducted primarily to test the feasibility and usability of HeadCoach, and to examine, through self-reported responses, early evidence of its effectiveness in changing managers’ level of confidence regarding dealing with mental health matters in the workplace. In order to maximise the opportunity to test the functionality of the product and receive substantial feedback on the processes and the quality of training, all participants were allocated to receive the intervention. Participants were managers employed by one of the two industry partners collaborating on the pilot study. Managers provided informed consent to participate in the study via an online form.

Recruitment

Two organisations in Australia volunteered to participate in the pilot evaluation of HeadCoach. One organisation was an equipment and machinery hire company servicing Australia across metropolitan, regional and remote areas. Managers in this organisation were staff responsible for branches and employees across one or more offices or region. The second organisation was a state-wide fire and rescue service. Managers in this organisation who were eligible for this pilot study were staff at the duty commander or station officer level, responsible for one or several different fire stations. For both organisations, the managerial level identified as relevant for the pilot study comprised supervisors that were the primary contact for staff members regarding periods of sickness absence or when workplace issues arose.

To be considered eligible for participation in the pilot study, managers were required to be currently supervising a team of three or more employees, be aged 18 years or older, and currently residing in Australia with good English comprehension. Sixty-six managers, identified by their employer as meeting criteria, were contacted via email by the researchers. The email described the purpose of
the research, outlined what would be involved, and contained a link to register for the pilot study. In addition, the email emphasised that although participation in the trial was supported by their employer, it was entirely voluntary, and their level of involvement in the study would remain confidential from their employer.

Procedure

The trial procedure and stages of assessment for the participants are outlined in Figure 1. Managers eligible to participate in the study received an information email from the researchers, inviting them to participate in the study. A hyperlink provided in the email directed the participant to the HeadCoach study website which contained further information about the program, the online consent form and registration page. Once registration was complete, the online baseline assessment was made available. Once the baseline assessment was completed, participants were able to commence the online HeadCoach manager training program. The design of the program allowed managers to work through the program at their own pace over a 4-week period. Emails were automatically distributed weekly from sign up until the participant had completed the program. These emails informed participants of the time remaining to complete the program and served as a reminder to revisit their account to continue working through the program.

Follow-up questionnaires were disseminated at 4-weeks post completion of the baseline questionnaire. This 4-week period comprised the training period allocated to managers to complete HeadCoach. If a manager finished all components of the online program earlier in the 4-week training period, they were invited to complete the post questionnaire at that time point. This approach was selected to reduce non-response.
Figure 1. HeadCoach Pilot Study Procedure Flow

Data Collection

Baseline and post-intervention data were collected electronically via the research platform that hosted the HeadCoach program. This allowed for a streamlined process between completing the HeadCoach program and completing questionnaires. In the case of non-response, two reminders were automatically sent across the subsequent 10 days via the research platform. Once the 4-week post-intervention questionnaire was completed, the HeadCoach content was made available again for the individual participant within their account for their own reference.
Measures of usability and feasibility

At the 4-week post-intervention follow up, participants were asked whether “This online course was engaging and interesting?” with response options ranging from strongly disagree to strongly agree. In addition, questions were asked evaluating the ease of navigating the program and finding information, whether the course met the individuals’ expectations, and how likely would they recommend the program to their colleagues. Participants were also given the opportunity to provide detailed feedback through additional free text questions, including suggestions on what should be included in future versions. Finally, data regarding completion rates including length of time taken to complete each module was obtained from the research platform database.

Measures of effectiveness

Managers’ confidence in managing mental health issues and promoting a mentally healthy workplace was measured using a modified version of previously published supervisor scales [19]; knowledge about common mental health was measured using the first 6 questions of the Mental Health Knowledge Schedule (MAKS)[37]; non-stigmatising attitudes towards mental illness was assessed using a modified version of previously published measures of personal stigma [38-40]; understanding of own role as a manager in dealing with mental health in the workplace was measured using a questionnaire developed based on the core competences outlined in a report detailing managers’ role in supporting return to work after ill health [20]; and managers’ application of managerial techniques that promote a mentally healthy workplace was assessed using an adapted version of the HSE Management Standards Indicator Tool [17]. These questions were asked at baseline and at the 4-week post-intervention assessment. Individual participants' scores were converted to a percentage of the maximum possible score prior to analysis of the data.
Demographic information including age, gender, job role and length of service in role, number of employees currently supervising and previous mental health training was also collected.

Statistical Analysis

Participants use of the training program was described in terms of total time and number of modules completed. Descriptive statistics were also used to demonstrate participants’ responses to questions on the usability and acceptability of HeadCoach. Differences in the mean percentage scores of each of the outcomes between baseline and post-intervention collected at 4-week follow-up were examined using paired samples t-tests. These included managers’ confidence in managing mental health issues within the workplace, level of mental health literacy, non-stigmatising attitudes towards mental illness, understanding of their own role in managing mental health issues within their team, and application of managerial techniques that promote a mentally healthy workplace. Statistical analysis was conducted using SPSS version 23.

Results

All managers were recruited during November and December 2016, with the post-intervention data collected during December 2016 and January 2017. Of the 66 managers who were invited to participate in the HeadCoach pilot, a total of 39 (59.1%) registered and completed baseline. All managers were assigned to receive the intervention. Demographics of the sample are detailed in Table 2.
Table 2: Demographics as reported at baseline.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (SD)</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>45.03 (8.74)</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>34 (87.2)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>5 (12.8)</td>
<td></td>
</tr>
<tr>
<td>Industry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Building/Construction</td>
<td>12 (30.8)</td>
<td></td>
</tr>
<tr>
<td>Emergency Services</td>
<td>27 (69.2)</td>
<td></td>
</tr>
<tr>
<td>Years at Current Employer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1 year</td>
<td>3 (7.7)</td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>5 (12.8)</td>
<td></td>
</tr>
<tr>
<td>5-10 years</td>
<td>5 (12.8)</td>
<td></td>
</tr>
<tr>
<td>10-15 years</td>
<td>4 (10.3)</td>
<td></td>
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<tr>
<td>&gt;15 years</td>
<td>22 (56.4)</td>
<td></td>
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<tr>
<td>Years in this level or above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1 year</td>
<td>6 (15.4)</td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>9 (23.1)</td>
<td></td>
</tr>
<tr>
<td>5-10 years</td>
<td>14 (35.9)</td>
<td></td>
</tr>
<tr>
<td>10-15 years</td>
<td>6 (15.4)</td>
<td></td>
</tr>
<tr>
<td>&gt;15 years</td>
<td>4 (10.3)</td>
<td></td>
</tr>
<tr>
<td>Modules completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>7 (17.9%)</td>
<td></td>
</tr>
<tr>
<td>1-7</td>
<td>8 (20.5%)</td>
<td></td>
</tr>
<tr>
<td>8-14</td>
<td>4 (10.3%)</td>
<td></td>
</tr>
<tr>
<td>15 (Completed program)</td>
<td>20 (51.3%)</td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>9.08 (6.62)</td>
<td></td>
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</table>

Usability and feasibility of *HeadCoach*

Over half of the sample (51.3%; n=20) completed the *HeadCoach* program. The time taken to complete the program ranged from 43 minutes to 2 hours 53 minutes. Feedback on the program was obtained through the post-questionnaire. Of those who responded (n=22), 77% (n=17) found *HeadCoach* engaging and interesting, 86% (n=19) agreed it was easy to find the information needed, 73% (n=16) reported that the program met their expectations, 91% (n=20) considered it useful, and 86% (n=19) would recommend *HeadCoach* to a friend.

The qualitative feedback received in the post-evaluation was primarily positive. The practicality of the information and the format it was presented in was reported as highly valued by the participants. Examples of comments reflecting these views included, “This topic was useful in giving logical and practical guidance on early intervention and strategies to minimize harm occurring in the workplace,” “Good tips on initiating conversations and advice on where to go for resources”, “It was great to get some practical examples and information that could be used in my workplace” and “Very well
explained and easy to understand”. Comments around improved confidence included “I found that it [HeadCoach] consolidated what I had covered previously in training and in doing so gave me more confidence to address an issue should one arise” and “[HeadCoach] gave me a bit more confidence in my approach”. Suggestions provided about the level of detail included about common mental illnesses (e.g. “Having a family history with mental illness, I hoped this course may be more informative, it tends to be a little superficial or shallow in details of symptoms to look out for”) were noted.

Effectiveness of HeadCoach

As shown in Figure 2, following their use of HeadCoach, managers had significantly higher levels of self-reported confidence in communicating with employees regarding mental illness ($t(22)=4.180, P<0.001$) and actions to employ managerial strategies to prevent and reduce stress among their team ($t(21)=2.468, P=0.02$). There was also a significant increase in managers’ knowledge regarding their role in managing mental health issues ($t(23)=2.881, P=0.01$). At follow up there was no significant change in non-stigmatising attitudes towards mental illness ($t(23)=-0.268, P=0.80$) while the increase in levels of mental health knowledge fell just short of statistical significance ($t(24)=1.987, P=0.06$).
**Figure 2:** Baseline and 4-week post intervention mean average scores (%) and Standard Error of Means for outcomes. *Significant difference between pre and post score P<0.05

**Discussion**

This pilot study evaluated the feasibility, usability, and likely effectiveness of *HeadCoach*, a newly developed online training intervention for workplace managers regarding the mental health needs of employees reporting directly to them. To the best of our knowledge, *HeadCoach* is the first educational program for managers delivered entirely online that provides an integrated program of preventive and reactive content in line with recently recommended best practice frameworks for workplace mental health [4, 15].

In this pilot study, relevant data to evaluate the feasibility of recruitment and participation processes, and the usability of the program, was collected through self-reported measures and also objectively as provided via the online research platform. This online platform has the potential to provide
valuable information regarding adherence and engagement [41]. Findings suggest that for

_HeadCoach_, the online recruitment and registration processes, as well as methods for obtaining data and delivering course material as operated through the current online research platform, were a practical and acceptable means for the dissemination and collection of the various forms of information.

Results from this pilot study also suggest that _HeadCoach_ was associated with significant increases in managers’ knowledge of their role in managing mental health issues among their staff, their confidence to do so, and their application of management strategies to promote a mentally healthy workplace. These changes in manager outcomes correspond to previous results from RCTs evaluating face-to-face training for managers promoting both reactive and preventative strategies to manage mental health issues within their team [22, 26]. Although in this pilot study the effect of _HeadCoach_ was only evaluated with a pre-post design, these preliminary findings remain important as they suggest that eLearning options may be able to replicate the positive outcomes previously reported with face-to-face manager training. This is an encouraging prospect as, if proven, it would allow organisations a practical means of training a large number of managerial staff about mental health issues with minimal time away from their jobs. Online training is also a flexible and convenient format of learning as it can be structured to fit around other responsibilities and deadlines managers are required to meet in their daily role. Therefore, although further evaluation through an RCT is required, these findings suggest the potential of _HeadCoach_ to provide feasible, acceptable and effective workplace mental health training for managers.

Despite the novelty of our findings, there are a number of important limitations. As mentioned previously, the sample size was small with just over half of participants providing post-intervention data. Although this rate of dropout is typical in studies of online training [41, 42], a higher response rate would be ideal to reduce any potential bias caused by nonresponse. The generalisability of results from this pilot study is limited by the opt-in approach to recruitment. The sample of managers
who agreed to participate and who completed the multiple components of the trial may have held a pre-existing awareness of mental health issues with an interest to further develop their skills to best support employees. This may also explain the lack of significant change found for managers’ mental health knowledge as the sample may have already been well informed of mental health issues, and therefore a ceiling effect may have been reached on these outcomes. Alternatively, the lack of significant effect may have been due to lack of power, and with a larger sample size, a significant change may have been found for these outcomes.

The absence of a control group further limits the conclusions that can be made regarding the efficacy of the intervention as other factors explaining the observed change cannot be ruled out. A further limitation was the short follow-up period included in this trial. Although a significant change was observed post-intervention, conclusions about the persistence of intervention effects over time cannot be made due to the lack of extended follow up. The short evaluation period included in the present study may have also been insufficient to allow managers the opportunity to display a change in attitudes within their work environment, yet with the inclusion of a longer follow-up, a change in non-stigmatising attitudes may potentially have been observed. A final potential limitation to note is the collection of self-reported data, particularly regarding confidence levels. Participants may be more likely to report their levels of confidence or behaviour favourably, although the use of identical questions at both time points and the anonymity of an online survey should have reduced this risk.

Conclusions

Although testing in a larger scale study with the inclusion of a control group is required to demonstrate a true effect, the preliminary findings from this pilot study suggest that HeadCoach may provide a practical and efficient method of training managers in best workplace mental health practices. Given the key role managers have in the promotion of mental health and well-being within their teams, there is great potential for this type of training to improve the support provided to employees for their mental health needs in the future.
Contributions

AG and SBH conceptualised and designed the study. AG, ADL, AM and SBH designed the intervention. AG acquired the data, and with SBH conducted the statistical analyses. AG and SBH drafted the manuscript. All coauthors contributed to the final manuscript.

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Conflicts of Interest

HC and SBH are employed by the Black Dog Institute which provides manager training to workplaces.
References


