



A redesigned training and staff support programme to enhance job retention in employees with moderate-severe depression.

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3 1 **A redesigned training and staff support programme to enhance job retention in**
4 2 **employees with moderate-severe depression**
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9 4 **Abstract**

10 5 **Purpose:** Closing the treatment gap in depression is vital to prevent people from losing their
11 6 jobs. Delivering group-based interventions at work could reach more employees than
12 7 delivering 1:1 interventions in a clinical setting.

13 8 **Design:** A mixed-methods exploratory sequential design with a high level of stakeholder
14 9 consultation was used to redesign an interdisciplinary Work-focused Relational Group CBT
15 10 Treatment Programme for moderate-severe depression. Qualitative data from focus groups
16 11 and quantitative data from a small feasibility study were integrated to develop the new
17 12 Training (and Staff Support) Programme (TSSP), which was fully specified and manualised
18 13 in line with the Template for Intervention Description and Replication (TIDieR) for future
19 14 delivery.

20 15 **Findings:** Focus groups identified a need for improved acceptability and accessibility of the
21 16 tertiary preventative Work-focused Relational Group CBT Treatment Programme. This
22 17 programme was therefore simplified for delivery by peer facilitators at the worksite as an
23 18 intervention for all employees rather than an indicated/targeted intervention for only those
24 19 with symptoms/risk of depression. The TSSP comprised a compulsory trauma-informed
25 20 educational/experiential workshop over four days plus optional open-ended, peer-led base
26 21 groups set up and run by volunteer peer facilitators.

27 22 **Social implications:** The worksite TSSP provides a democratic learning space and
28 23 empowers employees to stay at work by self-managing their symptoms and by challenging
29 24 the interpersonal dynamics and organisational structures that might precipitate and
30 25 perpetuate depression.

31 26 **Originality:** Our intervention is fully specified and manualised with an explicit programme
32 27 theory, unlike most universal worksite-based CBT programmes.

33 28 **Article classification:** Research Paper
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30 Introduction

31 Depression and anxiety account for over half of all work-related illness and work-related
32 sickness absences (Health and Safety Executive, 2020). An estimated 30% of the UK
33 workforce is diagnosed with a mental health condition at some point in their lifetimes
34 (Business in the Community, 2019). Employees with depression are at higher risk of
35 sickness absence and they have a poor return-to-work prognosis (Ervasti *et al.*, 2015). Many
36 affected individuals have recurrent episodes of depression, resulting in socioeconomic and
37 health-related sequelae including a higher risk of job loss and long-term depression-related
38 disability (Ervasti *et al.*, 2015, Lerner *et al.*, 2004). Unemployment is associated with a range
39 of health inequalities and poor wellbeing as well as stigma, social exclusion, and poverty
40 (Elliott, 2016). Furthermore, people with depression from minority and marginalised
41 communities may experience cumulative disadvantages and adversities (Brown *et al.*, 2016).
42 Therefore, there is an urgent need to enhance job retention in employees with recurrent
43 depression, preferably intervening before people take sickness absence. While screening
44 can help to prevent depression in the workplace (Couser, 2008), occupational health
45 services are generally provided to employees who are already absent and rarely offer help to
46 employees struggling to stay at work due to mental health problems. While tertiary
47 preventative interventions such as work-based depression programmes exist (Bond *et al.*,
48 2019), they are mainly designed to accelerate return to work in symptomatic employees.
49 Whilst work resumption is an important aspect of job retention, many depressed employees
50 do not take sickness absence and, if they do, they may not seek help.

51 Given that workplaces provide access to a large proportion of the adult population, they are
52 ideal settings for preventative interventions targeting depression (Tan *et al.*, 2014).
53 Workplaces have become important settings for mental health promotion, providing benefits
54 to both employers and employees (Czabala *et al.*, 2011). Despite this, services often work in
55 isolation, with employment programmes tending to ignore health and healthcare services
56 tending to ignore work (Francis *et al.*, 2008). Most adults receive no, or suboptimal, care and
57 treatment for depression (Bond *et al.*, 2019, Cuijpers, 2015, Thornicroft *et al.*, 2017), and
58 existing work-focused interventions have limited impact because employees with depression
59 face significant political, economic, healthcare, organisational, and personal barriers to
60 treatment and job retention (Collins *et al.*, 2004, Lammerts *et al.*, 2016). Ultimately,
61 delivering treatment programmes as tertiary preventative interventions at the individual level
62 does little to close the 'treatment gap' in depression.

63 **We recently tested the feasibility of a new, interdisciplinary Work-focused Relational Group
64 CBT Treatment Programme for moderate-severe depression [redacted *et al.*, 2021]. While
65 the new programme showed promising immediate positive outcomes in terms of depressive**

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3 66 symptoms, interpersonal difficulties, and job retention, we hypothesised that redesigning this
4 67 intervention to improve acceptability and accessibility would further help to enhance the
5 68 utility of the intervention and therefore job retention in UK employees with moderate-severe
6 69 recurrent depression. Based on a cumulative analysis of quantitative and qualitative data
7 70 from the feasibility study and qualitative data from post-intervention focus groups, here we
8 71 present a re-design of the Work-focused Relational Group CBT Treatment Programme,
9 72 namely the new Training (and Staff Support) Programme (TSSP).
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74 **Methods**

75 *Study design and ethical statement*

76 A multi-phase mixed-methods exploratory sequential design was adopted comprising a two-
77 stage stakeholder consultation process (qualitative data) and an embedded pilot study
78 (quantitative data; see redacted *et al.*, 2021). Stakeholders were consulted before the pilot
79 study during the review period. Purposive sampling was used to recruit participants with
80 appropriate knowledge and experience for ten focus groups of 1-3 hours. The sample
81 included 13 former service-users and 15 frontline practitioners and managers, most of whom
82 had experienced group CBT in secondary mental healthcare or job retention interventions
83 within the last two years.

84 Similarity criteria (such as shared experience) were used to guide the composition of
85 different focus groups (e.g., former service users in Group A, frontline practitioners and
86 managers in Group B, a mix in Group C). This helped to obtain a cross-section of opinions in
87 a welcoming atmosphere fostered by common interests.

88 Group A considered possible components of the intervention as well as practical issues
89 around implementation; Group B, research procedures and practical issues around
90 evaluation; and Group C the comprehensibility of the theoretical manual and other resources
91 and the overall helpfulness of the intervention with reference to users' feedback and the
92 preliminary analysis of outcomes.

93 The University [redacted] Research Ethics Committee, the NHS Local Research Ethics
94 Committee (LREC) via IRAS, and the NHS Trust's Research and Innovation department
95 approved the study protocol. The study conformed to the Declaration of Helsinki (World
96 Medical Association, 1996) and Good Clinical Practice (Medicines and Healthcare products
97 Regulatory Agency, 2012). The study was indemnified by the University of [redacted]. All
98 participants provided written informed consent.

99 *Data analysis*

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3 100 The data from all stages of the study were integrated to propose ways of improving the
4 101 intervention using a mixed methods data integration approach (Fetters *et al.*, 2013, Gallo
5 102 and Lee, 2015) that merged quantitative data from the feasibility study (preliminary
6 103 outcomes, therapeutic alliance, and client satisfaction), qualitative data from the feasibility
7 104 study (clients' and co-facilitators' feedback), and qualitative data from the focus groups. The
8 105 joint display method (Guetterman *et al.*, 2015) was used to integrate and interpret the
9 106 merged results, and the data were further integrated through a staged narrative approach
10 107 (Fetters *et al.*, 2013). This process culminated in the re-design of the intervention as a
11 108 Training (and staff support) Programme (TSSP) informed by relational group CBT.
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20 110 **Results**

21 111 *Qualitative and quantitative data from the feasibility study*

22 112 The Work-focused Relational Group-CBT Treatment Programme is outlined using the
23 113 Template for Intervention Description and Replication (TIDieR) checklist (Hoffmann *et al.*,
24 114 2014) in **Supplementary Table 1**. Briefly, the programme consisted of (i) up to four 1:1
25 115 psychotherapy sessions; (ii) twelve work-focused, full-day, weekly group CBT sessions
26 116 facilitated by a cognitive behavioural therapist and occupational therapist; and (iii) up to four
27 117 optional 1:1 sessions with an occupational therapist. The quantitative results of this feasibility
28 118 study conducted in eight women with moderate-severe depression are reported in redacted
29 119 *et al.* (2021). BDI-II depression scores significantly decreased after therapy (n=8; -20.0
30 120 median change, p=0.016; 6/8 responses, 7/8 minimal clinically important differences, two
31 121 remissions), and there were significant improvements in the secondary outcomes of overall
32 122 psychological distress, coping self-efficacy, health-related quality of life, and interpersonal
33 123 difficulties after therapy. All clients in work at the start of therapy remained in work at the end
34 124 of therapy. The intervention was safe and had 100% retention.

35 125 As assessed by the Agnew Relationship Measure (ARM)-5 after each session, there were
36 126 positive bonds and partnerships with the co-facilitators and confidence in the treatment. The
37 127 mean client satisfaction measured by the Client Satisfaction Questionnaire (CSQ)-8 was
38 128 27.0 (SD 2.08), suggesting that clients were highly satisfied with their overall treatment.

39 129 After the programme, clients were asked to: (i) name one positive/negative thing standing
40 130 out about the programme; and (ii) report whether there was anything that they thought
41 131 should be included in/removed from the programme.

42 132 Most clients found talking together in a group positive, particularly for conflict resolution in
43 133 the group setting and needing to participate. However, participants found the written
44 134 materials very dry and that they read more like a manual for psychotherapy professionals

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3 135 than for lay people. One participant thought there were too many goals to achieve each
4 136 week, and two participants found certain aspects “very repetitive” such as “going over the
5 137 goals twice [in pairs and in plenary]”.

8 138 *Post-intervention qualitative data from the focus groups*

10 139 Mixed focus groups were conducted and, overall, two main themes were identified for
11 140 improvement: improving *acceptability* and improving *accessibility*.

14 141 With respect to *improving acceptability*, two themes to improve acceptability were: i) making
15 142 the programme more interesting and stimulating; and ii) focusing on long-term coping. With
16 143 respect to *improving accessibility*, three themes were identified that might improve
17 144 accessibility: i) making it more understandable; ii) delivering it at the worksite; and iii) making
18 145 it peer led.

22 146 *Programme re-design to create a Training (and Staff Support) Programme (TSSP) informed*
23 147 *by relational group CBT*

26 148 Data integration from the feasibility study (preliminary outcomes, therapeutic alliance, and
27 149 client satisfaction), qualitative data from the feasibility study (clients’ and co-facilitators’
28 150 feedback), and qualitative data from the focus groups suggested how the intervention could
29 151 be improved (**Figure 1**). Details of the changes made to the treatment programme as a
30 152 result of feedback are detailed in **Supplementary Table S2**.

34 153 The Training (and Staff Support) Programme (TSSP) informed by relational group CBT is
35 154 outlined using the TIDieR checklist in **Table 2**. Briefly, the intervention was simplified so that
36 155 it could be delivered by peer facilitators at the worksite, as an intervention for all employees,
37 156 rather than an indicated/targeted intervention for only those with symptoms/risk of
38 157 depression. The TSSP comprised a compulsory trauma-informed educational/experiential
39 158 workshop over four days followed by optional open-ended, peer-led base groups set up and
40 159 run by volunteer peer facilitators. For details, see **Table 2**.

45 160 Field testing of the TSSP was conducted with the local authority and Early Help workforce
46 161 and found to be feasible, although there were problems in delivering the course to large
47 162 teams and acceptability of the subject matter.

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52 164 **Discussion**

54 165 Widespread adoption of a psychotherapeutic TSSP delivered at the worksite, ideally before
55 166 employees go off sick, has the potential to close the treatment gap in depression and to
56 167 transform the organisational culture. One randomised controlled trial (RCT) evaluated a
57 168 universal ‘Coping with Strain’ course based on CBT delivered in group format at a worksite

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3 169 setting (Saelid *et al.*, 2016). Unsurprisingly, baseline mean BDI-II scores were in the mild
4 170 range. The intervention, which was adapted from the 'Coping with Depression' course but
5 171 with a work focus to the content and between-session assignments, consisted of eight
6 172 weekly sessions with 8-12 group members for 2½ hours plus two booster sessions in the
7 173 follow-up period. This intervention was associated with a significant and sustained reduction
8 174 in depressive symptoms during the course, but no work outcomes were reported. Our TSSP
9 175 could similarly impact both depressive symptoms and work outcomes, a hypothesis that
10 176 warrants formal testing in a prospective trial.

11 177 A large systematic review of international guidelines on workplace mental health found that
12 178 prevention is not prioritised as highly as detection and treatment, and recommendations for
13 179 preventative interventions tend to be delivered at the individual rather than organisational
14 180 level (Memish *et al.*, 2017). However, a 'bits and bobs' approach (e.g., mental health literacy
15 181 courses) is unlikely to address structural and systemic factors that cause occupational
16 182 stress. In comparison, our intervention was designed for employees with more severe and
17 183 chronic depression and redesigned to transform the workplace culture as a way of
18 184 enhancing job retention.

19 185 The operational logic (Astbury and Leeuw, 2010) of our intervention mirrors other psycho-
20 186 educational courses delivered at the worksite, such as Mental Health First Aid (MHFA).
21 187 However, although MHFA opens up conversations about mental health, it does not change
22 188 organisational culture (Narayanasamy *et al.*, 2018), and MFHA has not had a noticeable
23 189 impact on encouraging employees to seek help (Attridge, 2012, DeFehr, 2016, Knaak *et al.*,
24 190 2018, Morgan *et al.*, 2018). MFHA may in fact reinforce stigma by using psychiatric
25 191 diagnoses that can create a 'them and us' culture, with providers seen as mentally healthy
26 192 and recipients as unhealthy (Corrigan, 2017, DeFehr, 2016). The 'othering' of people with
27 193 mental health problems is also possible when managers are trained apart from employees,
28 194 as if managers cannot have mental health problems. Our intervention trains managers and
29 195 employees together, which may help to overcome a reported lack of trust between the two
30 196 groups (Business in the Community, 2019). The redesign is consistent with several studies
31 197 showing that it is possible to prevent depression via innovative methods of delivering
32 198 psychotherapeutic interventions (Cuijpers and Holte, 2015, Wahle *et al.*, 2017). There is
33 199 strong evidence that workplace psychotherapeutic and universal CBT-based or
34 200 psychoeducational interventions delivered at primary prevention level can prevent
35 201 depression and reduce symptoms (Yunus *et al.*, 2018).

36 202 Recruiting peer facilitators to deliver the intervention at the worksite is supported by four
37 203 decades of research, which recommends that research should not attempt to tackle the
38 204 disease burden by creating new models and formats, since most are equivalent in

205 effectiveness, but rather by ‘training people to become lay counsellors’ and scaling up
206 interventions (Cuijpers *et al.*, 2017). Low-intensity psychotherapeutic interventions provided
207 by non-psychologists can also shorten the length of time depressed employees take off sick
208 (Doki *et al.*, 2015).

209 The conceptual logic (Astbury and Leeuw, 2010) of our intervention mirrors to some extent
210 the IGLOO model (Nielsen *et al.*, 2018). IGLOO is a conceptual framework to enhance
211 sustainable return to work (SRTW) in employees with mental health problems and uses
212 occupational health psychology theory. SRTW is an important aspect of job retention in that
213 some employees with depression require time off sick to recover (although some may stay at
214 work while symptomatic). IGLOO focuses on both work and non-work resources that enable
215 someone to resume work successfully. The TSSP draws on the resources of the individual
216 (employee), the group (co-workers), the leader (managers), and the organisational context
217 (workplace) to prevent relapse and recurrence of depression as a way of maintaining
218 employment, in contrast to interventions designed using the IGLOO model, which focus on
219 SRTW.

220 Our intervention works at micro and meso levels and therefore falls short of a multi-level
221 conceptualization of the relationship between the psychosocial work environment and
222 employee mental health (Martin *et al.*, 2016). This framework recommends considering
223 macro-level factors such as the political, economic, and cultural context, meso-level factors
224 such as team climate and organisational environment, and micro-level factors such as
225 employees’ vulnerabilities and strengths when designing organisational interventions.
226 However, our intervention is based on the Person-Environment-Occupation model (Law *et al.*
227 *et al.*, 1996) as a conceptual framework for understanding how intra-personal, inter-personal,
228 and work factors interact to affect someone’s ‘occupational performance’ across the lifespan
229 to develop personalised care plans, which might compensate for this design flaw.

230 Since the TSSP is a combined intervention (i.e., aims to bring about change at the individual
231 and organisational level), it may fill a gap in research and practice. One review investigated
232 the mediators of change in combined vocational rehabilitation interventions for burnout
233 (Pijpker *et al.*, 2020). Most of these interventions were based on different occupational stress
234 theories, with only one based on CBT. Overall, the interventions were effective by: 1)
235 involving employees in decision-making; 2) enhancing their job control and social support;
236 and 3) eliminating stressors in the workplace. Our intervention also targets some of the
237 intra- and inter-personal factors that precipitate and perpetuate moderate-severe recurrent
238 depression. Moreover, setting up opportunities for all employees to practise ‘the art of good
239 conversation’ could foster protective factors such as respect, civility, and collegiality in the
240 workplace.

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3 241 The TSSP partially satisfies the 'integrated intervention' approach proposed by LaMontagne
4 242 *et al.* (2014) by promoting mental health and addressing mental health problems regardless
5 243 of cause. It is also compatible with national and international guidelines in terms of the need
6 244 for mentally healthy or psychologically safe workplaces (Harvey *et al.*, 2014, Leka *et al.*,
7 245 2010, NICE, 2009).

8 246 A worksite training programme could create or reveal a range of tensions and conflicts which
9 247 could derail its implementation (Karanika-Murray and Biron, 2015). First, psychotherapeutic
10 248 interventions may meet resistance in some employees. A study of a training programme for
11 249 university staff was designed to improve the capacity for 'empathetic attunement' (Brandão
12 250 *et al.*, 2016), a skill thought to underpin positive peer relationships between staff at all levels,
13 251 but the study found there were significant individual differences in self-defensiveness in one-
14 252 third of participants when asked to learn a new and unfamiliar skill. Most of these
15 253 participants became less defensive as the trainers provided a secure training context.

16 254 Second, psychotherapeutic interventions are potentially triggering for some employees and
17 255 this may deter organisations from investing because of the risk of vicarious liability.

18 256 Moreover, although the intervention is designed as a universal preventative programme to
19 257 obviate the need for disclosure, there is a risk of exposure which may inadvertently 'out'
20 258 those with mental health problems. Thus, many employers outsource corporate health
21 259 completely (Lier *et al.*, 2019), limiting the impact of psychotherapeutic interventions on
22 260 organisational culture.

23 261 Third, employees may wish to avoid taking part in any intervention which they perceive as
24 262 the employer trying to 'fix' them. Organisational reliance on training programmes to improve
25 263 employee mental health, often delivered as a superficial panacea or as an 'antidote to
26 264 uncertain times' (Bevan and Bajorek, 2018), is likely to inculcate a sense of alienation,
27 265 cynicism, and hostility rather than openness, authenticity, and compassion within workplace
28 266 relations. There are often fears about hidden agendas (Higgins *et al.*, 2012), and some
29 267 employees may prefer a service that is independent, impartial, confidential, and based away
30 268 from the worksite.

31 269 Finally, the construct of 'resilience' is problematic in this context because when employees
32 270 complain about not being able to cope with a high workload, the problem is located in them
33 271 due to an apparent lack of 'resilience' for which they need training to develop. But by 'coping'
34 272 with the situation, employees may be tacitly legitimising working practices that are
35 273 unreasonable. As noted by (Saltmarsh, 2016), the 'stress-free life [is seen] as the
36 274 responsibility of the individual, even though it may be the institution itself that produces the
37 275 stress being experienced'.

276 Therefore, worksite training programmes need to be set up with the same thorough
277 preparation as treatment programmes delivered in clinical settings. Nevertheless,
278 redesigning our tertiary individual-level treatment programme as a primary organisational-
279 level TSSP has the potential to enhance job retention in all employees, particularly those
280 vulnerable to relapse and recurrence of depression.

281 **Limitations**

282 We invited stakeholders to consider the results from the feasibility study, but the conclusions
283 from this study needed to be treated as partial and non-generalisable due to a very small
284 purposive sample; a single location; the possibility of selection or relationship bias; and
285 because the context for the study may be very different to other clinical, worksite, or
286 community contexts. However, this methodological weakness was compensated for through
287 data integration from all stages of the research. Data integration did not use blinding, but the
288 risk of analytical or confirmation bias was mitigated by a high degree of research
289 governance: the study was closely supervised by a senior clinician and academic, ensuring
290 robustness of the interpretations of the findings.

291 **Conclusions**

292 Here we present a novel TSSP informed by relational group CBT for employees of health
293 and social care organisations, paving the way for formal quantitative testing of its efficacy.
294 The intervention design and the programme theory are unique because they were developed
295 in consultation with stakeholders to identify active ingredients and mechanisms of change.
296 Both the TSSP are fully specified and manualised in line with the TiDIER checklist and
297 guidance so that they can be delivered with fidelity in any future trial.

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444 **Figure Legend**

445 Figure 1. Integration of the data using the joint display method (Guetterman *et al.*, 2015) to
446 improve the intervention.

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Table 1. The revised Training (and Staff Support) Programme (TIDieR compliant)

	BRIEF NAME
1	<i>Provide the name or phrase that describes the intervention</i>
	A Training (and Staff Support) Programme (TSSP) informed by relational group CBT for employees of health and social care organisation, and others who offer services to people with complex needs.
	WHY
2	<i>Describe any rationale, theory, or goal of the elements essential to the intervention</i>
	<p>There is a lack of knowledge about job retention interventions that aim to improve employees' communication and interaction skills in high-stress occupations such as nursing, teaching, and social work and whether they have an impact at individual, organisational, and service-user levels.</p> <p>This intervention is designed to help employees gain knowledge about, skills to manage, and positive attitudes towards stress and trauma and to enhance relational ways of working. It targets dysfunctional communication and interaction patterns and maladaptive coping frequently seen in people with complex needs.</p> <p>Peer-led 'Base Groups' for staff provide emotional and practical support and a psychologically safe environment where new ways of coping can be developed. The goals of the intervention are improved clinical, inter-personal, and occupational outcomes for employees and service users.</p>
	WHAT
3	<i>Materials: describe any physical or informational materials used in the intervention, including those provided to clients or used in intervention delivery or in training of intervention providers. Provide information on where materials can be accessed (such as online appendix, URL)</i>
	<p>For employees, there is a range of educational resources including a manual, DVDs, and recordings. There is a range of educational resources and a manual. These can also be used in direct work with families.</p> <p>For workshop facilitators, there are PowerPoint presentations which give clear details for the first four sessions and which explain the approach.</p> <p>For 'Base Group' peer facilitators, there are suggested session formats and handouts.</p>
4	<i>Procedures: describe each of the procedures, activities, and/or processes used in the intervention, including any enabling or support activities</i>
	The preparation process for the educational workshop involves a 1:1 meeting with the workshop facilitator to orientate employees about the programme and to screen for any mental health problems and current stressors using CORE-OM and the HSE risk tool. The Coping Self Efficacy questionnaire will identify what coping strategies the employee typically uses. The employee is given the manual and contact details of the workshop facilitator.

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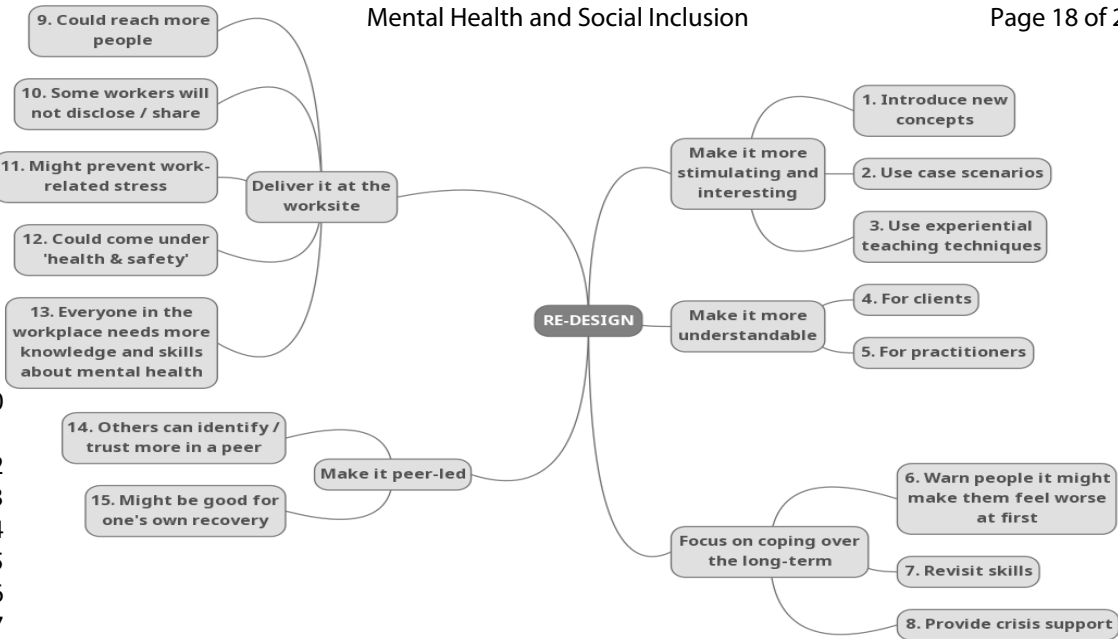
	<p>All employees undertaking the training programme are asked to sign a confidentiality agreement.</p> <p>The educational workshops comprise four full day sessions over four weeks with assignments prescribed before / between / after each session. The workshops start with ice breakers / warm up games to reduce anxiety and accelerate group cohesion. The workshops are mainly used to socialise members to the relational ways of working model; to provide educational material via didactic presentations, videos, and experiential exercises based on adult learning principles; and to promote self-disclosure and feedback processes between employees. This involves presentation of information about stress and basic neuroscience, the relevance of trauma, dysfunctional personal and inter-personal coping styles, and opportunities to practice skills <i>in vivo</i>. Facilitators use a range of strategies such as reciprocating pairs, small groups, and plenary sessions to orientate workshop members to take on an active role in their own learning and also to take an active role in other employees' learning.</p> <p>Following completion of the four sessions, another 1:1 meeting with the workshop facilitator is arranged to de-brief the employee and to offer feedback about their participation.</p> <p>All employees who have completed the educational / experiential workshops will be invited to form or join a Base Group of between 6-8 members who commit to attend reliably for 2 hours on a weekly / fortnightly / monthly basis. Membership can be agreed as part of employees' performance appraisals or personal development plans.</p> <p>Each Base Group has a stable membership of between six to eight people who make a commitment to meet regularly for no less than 12 months. At each one-year anniversary, the members may decide to close the group, to split in half to form two new groups inviting other staff members to join, or to continue with the existing membership for another 12 months.</p> <p>Each session starts with 30 minutes reflection time when group members prepare a worksheet at the beginning of the session about something they have found stressful, upsetting, or disturbing between sessions which may be a work-related or a personal issue. Members work in pairs to build understanding of their triggers, automatic stress reactions, helpful or unhelpful coping strategies, for example. In a plenary slot, members summarise what their partner disclosed and then the group as a whole decides who might need more time to talk about what has happened and what might be helpful. Group discussion for the next 60 minutes focuses on processes such as re-appraisal, re-attribution, and re-processing. Before the end of the session, members complete their worksheet outlining how they could cope in a more adaptive way with any current stressors. These commitments are shared with others in the final 30 minutes before the session ends. If anyone requires additional support between sessions, this can be negotiated and agreed. The main goal of this group is to generate self-awareness and self-efficacy.</p>
	WHO PROVIDED
5	<i>For each category of intervention provider (such as psychologist, nursing assistant), describe their expertise, background, and any specific training given</i>
	<p>The intervention will initially require qualified psychotherapists / psychologists or other experienced mental health practitioners to facilitate the workshops and to support employees in setting up and running the peer-led Base Groups (which could involve attending the first 4 groups). The intervention involves a 'train the trainers' approach, as all components will be undertaken by employees eventually as they gain basic CBT concepts and skills. Base Group peer facilitators will have on-going monthly supervision with a psychological therapist. These volunteers will also have the opportunity to co-facilitate further educational / experiential workshops, and in time run them on their own.</p>

	HOW
6	<i>Describe the modes of delivery (such as face-to-face or by some other mechanism, such as internet or 'phone) of the intervention and whether it was provided individually or in a group</i>
	<p>The main mode of delivery is face-to-face workshops with some 1:1 briefing and de-briefing sessions. Contact via email and telephone with members of the project team would be available for troubleshooting purposes.</p> <p>Employees accessing a Base Group may negotiate additional support by telephone or text between sessions.</p>
	WHERE
7	<i>Describe the type(s) of location(s) where the intervention occurred, including any necessary infrastructure or relevant features</i>
	<p>The 1:1 briefing and de-briefing sessions will be conducted in suitable accommodation such as small meeting rooms. Privacy and confidentiality would be essential. The educational / experiential workshops should be conducted in suitable accommodation such as medium to large meeting rooms within buildings used by NHS or LA teams, or other free community venues. It is important for the room to be the same for every session and for there to be no interruptions. Facilities such as lifts and accessible toilets would be required.</p> <p>A PowerPoint projector would be required and agreement within local teams to photocopy handouts. Refreshments would be dependent on what the facilitators could feasibly arrange but should ideally include lunch.</p> <p>The Base Group sessions should be conducted in suitable accommodation such as small to medium meeting rooms within buildings used by NHS or LA teams or other free community venues. It is important for the room to be the same for every session and for there to be no interruptions. Facilities such as lifts and accessible toilets would be required.</p> <p>Refreshments would be dependent on what the facilitators could feasibly arrange but should ideally include a cold or hot drink.</p>
	WHEN and HOW MUCH
8	<i>Describe the number of times the intervention was delivered and over what period of time including the number of sessions, their schedule, and their duration, intensity, or dose</i>
	<p>The intervention comprises one 1:1 orientation / screening session of one hour duration, four full day weekly workshops, and an optional weekly / fortnightly / monthly Base Group (depending on how frequently the group members want to meet).</p> <p>Preparation for the intervention comprises one 1:1 briefing before the workshops and one 1:1 de-briefing session of up to 1 hour duration each session.</p> <p>The workshops comprise four weekly full day sessions over 4 weeks with up to 12 participants.</p> <p>The peer-led Base Group comprises one x 2 hour session on a weekly / fortnightly / monthly basis for minimum 12 months.</p> <p>Over 12 months, the intervention will reduce from high intensity with psychotherapists / psychologists heavily involved in running the programme to low intensity as peer facilitators working towards accreditation take over running the TSSP under continuing supervision.</p>
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9	<i>If the intervention was planned to be personalised, titrated or adapted, then describe what, why, when and how</i>
	The educational / experiential workshops should be mandatory to help all employees gain knowledge about, skills to manage, and positive attitudes towards stress and trauma. The intervention may be tailored in response to employee need, e.g., the provision of work-focused or personal feedback using the HSE checklist or CORE-OM or the recommendation to join a peer-led Base Group, for example.
	MODIFICATIONS
10	<i>If the intervention was modified during the course of the study, describe the changes (what, why, when and how)</i>
	The intervention has been substantially modified from a tertiary preventative Treatment Programme to this primary preventative Training (and Staff Support) Programme. This means that the original intervention has split into two components: 1) four weekly educational / experiential workshops, and 2) a follow-up weekly peer support group.
	HOW WELL
11	<i>Planned: if intervention adherence or fidelity was assessed, describe how and by whom, and if any strategies were used to maintain fidelity, describe them</i>
	Before and after each educational / experiential workshop, time should be set aside for shared reflection with both co-facilitators using the competency checklist. Any problems or concerns can be addressed in their own line management supervision or with members of the project team. Live supervision can be used to observe the co-facilitators' practice <i>in vivo</i> , to verify their competence, and to evaluate fidelity to the model through the use of the competency checklist as above. Quality assurance will be achieved over time through a process of peer evaluation by employees accredited as peer facilitators. Before and after each group session, time should be set aside for individual reflection by the facilitator using the competency checklist.
12	<i>Actual: if intervention adherence or fidelity was assessed, describe the extent to which the intervention was delivered as planned.</i>
	Field testing of the Training Programme has taken place with the Local Authority and Early Help workforce and found to be feasible, although there were problems in delivering the course to large teams and acceptability of the subject matter.

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3 **SUPPLEMENTARY MATERIALS**

4 **Supplementary Table S1. The Work-focused Relational Group CBT Treatment Programme (TIDier compliant).**

	BRIEF NAME
1	<i>Provide the name or phrase that describes the intervention</i>
2	A work-focused relational group-CBT Treatment Programme for employed people with moderate-severe recurrent depression.
3	WHY
4	<i>Describe any rationale, theory, or goal of the elements essential to the intervention</i>
5	<p>There is a lack of knowledge about indicated work-focused clinical interventions at the tertiary level (i.e., treatment and relapse prevention) to promote job retention.</p> <p>The intervention is based on the inter-personal theory of depression. It targets dysfunctional communication and interaction patterns frequently seen in people with depression that predict relapse and recurrence.</p> <p>Group psychotherapy provides an activating environment where new skills can be acquired, consolidated, and applied with the benefit of <i>in vivo</i> behavioural rehearsal, corrective peer feedback, contingent reinforcement, emotional co-regulation, and stimulus discrimination.</p> <p>The goals of the intervention are improved clinical, inter-personal and occupational outcomes.</p>
6	WHAT
7	<i>Materials: describe any physical or informational materials used in the intervention, including those provided to clients or used in intervention delivery or in training of intervention providers. Provide information on where materials can be accessed (such as online appendix, URL)</i>
8	<p>For clients there is a range of psycho-educational resources including a manual, DVDs, and recordings.</p> <p>For therapists there are PowerPoint presentations which give clear details for the first four sessions which explains the approach.</p> <p>All of these materials are available at www.group-CBT.com.</p>
9	<i>Procedures: describe each of the procedures, activities, and/or processes used in the intervention, including any enabling or support activities</i>
10	<p>The assessment and formulation process involves up to four 1:1 sessions undertaken by a Cognitive Behavioural Therapist.</p> <p>In the first session, clients complete a Family History questionnaire, Screening Checklist, Baseline Activity Tracking Diary, and a Crisis Plan.</p> <p>Clients are given some printed Information about depression, and a letter for their employer about the programme.</p> <p>Each client is asked to identify someone who will provide on-going support for the therapy outside of the session and to invite them to one of the assessment sessions. This person's perspective is sought about how depression affects their relationship, and they are asked to complete the</p>

Impact Message Inventory.

A summary of the assessment is written in the form of a letter to the client, which includes a diagram depicting an ideographic formulation of how recurrent depression is perpetuated by behavioural excesses or deficits which result in dysfunctional communication and interaction patterns at home and / or work. A treatment plan is agreed using a problems / goals format. One of the goals must specifically relate to job retention or return-to-work.

All group members sign a confidentiality agreement with behavioural guidelines made explicit to safeguard members' welfare.

The group psychotherapy programme comprises twelve full-day sessions over 12 weeks with prescribed homework after each session and written progress reports provided about the last session at the beginning of the next. The first four sessions all start with ice breakers / warm up games to reduce anxiety and accelerate group cohesion. They are mainly used to socialise members to the treatment model, to provide psycho-educational via didactic talks, videos and experiential exercises based on adult learning principles, and to promote self-disclosure and mutual trust between members. This involves presentation of information about RD, the relevance of trauma, and dysfunctional personal and inter-personal coping styles. Group facilitators use a range of strategies such as reciprocating pairs, small groups, and plenary sessions to orientate group members to take on an active role in their own therapy, and also to take an active role in other group members' therapy.

During the next eight sessions, group members are given an *in vivo* behavioural goal (e.g., ask someone for support, disagree with someone, offer an apology, or give someone a compliment), and other members guess what the person was trying to achieve at the end of the session.

Each group member can request up to four 1:1 sessions with the Occupational Therapist outside of the group sessions with a job retention / return-to-work focus. This may involve contact with the workplace, human resources, or Occupational Health services.

Each group member is offered up to two 1:1 sessions with a therapist if required during the course for the purposes of crisis resolution at home / work.

Group members also prepare a worksheet at the beginning of the session about an inter-personal situation with a significant other (at home / work) that they found challenging during the preceding week. Members work in pairs to build understanding of what each person did / said, as well as each person's thoughts and feelings. Different perspectives are encouraged in a re-processing plenary slot, with the aim of developing communication and interaction skills, as well as empathic concern for the significant other. Group discussion is focused on how a stress-inducing dynamic can change into a stress-reducing dynamic by a process of reparation. Learning may be enhanced using role play or the "empty chair" technique.

Each session also involves "small group" facilitated discussion, when the whole group splits into two halves for more intense psychotherapeutic work on individual goals / behavioural experiments / journal reflection for example depending on the individual's needs.

Members choose an activity in advance and take turns (one for each of the last eight sessions) for either "Telling my Story" (presenting information about themselves and their recovery journey in whatever form they wish to) or "The Hot Seat" (asking other group members to give honest feedback and observations about the person using a worksheet based on inter-personal skills and strengths).

At lunchtime, group members are given a "Teamwork Challenge", which consists of planning a celebratory event for the end of the programme together. Time is given after the lunchtime to reflect on how each member is engaging with this exercise and with unstructured social contact and how this relates to their individual work situations.

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3	All sessions include time for goal review and goal setting, with other group members encouraged to provide feedback and reinforcement as appropriate.
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6	In session 11, group members are given a Discharge Plan worksheet to complete prior to the last session, and in session 12, group members complete a Relapse Prevention Plan. They are also invited to write a post card addressed to themselves outlining what they have achieved in therapy and including motivational affirmations. The post card is sent to each member by the therapists four weeks after the last session.
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9	A further 1:1 session (with the significant other if appropriate) is offered in the week following completion of the intervention to discuss the Discharge Summary, which is written in the form of a letter to the person's referrer and GP reporting on progress towards goals with outcome measures.
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12	WHO PROVIDED
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14	5 <i>For each category of intervention provider (such as psychologist, nursing assistant), describe their expertise, background, and any specific training given</i>
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16	The intervention is delivered by a qualified CBT group psychotherapist and a qualified Occupational Therapist. Both should have significant experience in secondary care mental health service provision. Training in co-facilitation using behavioural and inter-personal process principles should be provided.
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22	6 <i>Describe the modes of delivery (such as face-to-face or by some other mechanism, such as internet or 'phone) of the intervention and whether it was provided individually or in a group.</i>
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24	The main mode of delivery is face-to-face group psychotherapy with additional individual sessions. Group members are also encouraged to contact the therapists by telephone, text, or email between sessions if the intervention has triggered distress or if they are uncertain about any aspect of the programme. They are informed that this contact should not be used as an out-of-hours emergency service. They are also informed not to expect an immediate reply and not to ring overnight or at weekends.
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31	7 <i>Describe the type(s) of location(s) where the intervention occurred, including any necessary infrastructure or relevant features</i>
32	The 1:1 sessions are conducted in suitable accommodation, such as within an outpatient or community mental health service.
33	A PowerPoint projector is required and capacity to photocopy handouts.
34	The group psychotherapy programme takes place in a large room with a break-out room, with facilities for refreshments and opportunity for unstructured social contact between group members.
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37	WHEN and HOW MUCH
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39	8 <i>Describe the number of times the intervention was delivered and over what period of time including the number of sessions, their schedule, and their duration, intensity, or dose</i>
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1		The intervention comprises twelve full day weekly group sessions over a period of 3 months. In addition, up to four 1:1 weekly or fortnightly assessment sessions of one hour duration, up to two 1:1 crisis resolution sessions of one hour duration (as required), one 1:1 discharge session of one hour duration, and up to four 1:1 Occupational Therapy session of up to 3 hours duration per group member.
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7		TAILORING
8	9	<i>If the intervention was planned to be personalised, titrated or adapted, then describe what, why, when and how</i>
9		The intervention is individually tailored through the optional addition of 1:1 sessions for crisis resolution, Occupational Therapy, and carer support.
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11		MODIFICATIONS
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13	10	<i>If the intervention was modified during the course of the study, describe the changes (what, why, when and how)</i>
14		N/A
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16		HOW WELL
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18	11	<i>Planned: if intervention adherence or fidelity was assessed, describe how and by whom, and if any strategies were used to maintain fidelity, describe them</i>
19		Before and after each group session time was set aside for briefing and de-briefing with both co-facilitators using a group CBT competencies checklist.
20		Live supervision included the Acting Head of the CBT Service attending 3 group sessions for one hour each time to observe the co-facilitators' practice <i>in vivo</i> . This live supervision was intended to evaluate fidelity to the model through the use of the competencies checklist as above.
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26	12	<i>Actual: if intervention adherence or fidelity was assessed, describe the extent to which the intervention was delivered as planned.</i>
27		The intervention was delivered per protocol and found to be feasible, although there was a low rate of recruitment because this intervention was delivered as a Treatment Programme in a clinical setting and relied on referrals from practitioners.
28		Live supervision only took place on one occasion due to competing demands on the time of the Acting Head of the CBT Service.
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Supplementary Table S2 – Changes made to the new intervention as a result of feedback

Concern expressed	Suggested changes	Changes made	Staff	SU
Not enough information about thinking styles.	Incorporate more basic cognitive restructuring components.	Use concept of primary and secondary appraisals derived from coping process theory and dual processing theory.	√	
Confusing if concepts are only presented in written form or lecture.	Elaborate concepts / provide clear explanations using case studies, examples from real life, personal scenarios in the session.	Use adult learning techniques and experiential exercises; pair work and small group discussion (“fleshing it out”).	√	√
Use of technical / academic terminology.	Make it less complicated, less dense, explain fewer ideas more fully, use less technical language; simplify how the concepts are described and depicted.	Present ideas using diagrams and more accessible language in the manual with fewer concepts provided, i.e., focus mainly on inter-personal behaviour, and use of language from “stress management” literature.	√	√
Could be boring and off-putting.	Present concepts in a more interesting, stimulating and engaging way; provide less information in a clearer way using illustrations / animations / experiential / face-to-face in the group.	Use lots of different activities to energise participants and make learning more fun; notes for facilitators added to 4 x PowerPoint presentations with notes on how to explain concepts in an accessible way.	√	√
Too many different potentially conflicting ideas (“conceptually not quite there yet”).	Work at further conceptual integration or only focus on a few concepts.	Rely on group process components to convey concepts implicitly (versus explicitly) such as inter-personal reciprocity and emotional co-regulation.	√	√
Reading manual as it stands could be exhausting if given out at the beginning of the course (“I was getting a bit worn out”).	Give manual out at the end of the programme with some between-session reading / tasks.	Make manual look more colourful and break up into digestible chunks so participants are encouraged only to read certain sections before or after specific sessions.		√
Possibility of crisis and relapse prevention (“getting worse before you get better”, “opening can of worms”, “plan for what	Provide participants with relevant information about who to contact if they feel worse.	All clients developed personalised crisis and relapse prevention plans using coping process theory.	√	√

happens when you have a blip”).				
Using inter-personal theory of depression may result in guilt and self-blame (“go back to square one”).	Support to make links between what person says / does and what others say / do; use compassionate feedback to improve awareness of how one’s behaviour impacts on others.	Brief and debrief interactive exercises carefully to ensure all participants have a positive experience.		√
Using role play could be unhelpful if one person is using therapist role “in an aggressive manner”.	Support to make links from “there & then” with “here & now”.	Provide 1:1 assessment and formulation; treatment plan with personalised problems / targets.		√
Not enough processing time between sessions if they were delivered more intensively, i.e., every day, twice-weekly.	Sessions to be full day delivered as weekly sessions.	Consideration given to frequency matching the intensity to participants’ needs / capacities.	√	
Too many goals and between-session assignments.	Prescribe fewer goals and between-session assignments.	Goal-setting process simplified and personalised.		√
DVDs didn’t work on some home computers; too much information if watched all at once.	Watch DVDs in the group, space them out.	DVDs watched together 2 per session with discussion.		√
Treatment Programme delivered in clinical setting is remote from the workplace.	Use it as a workplace preventative Training Programme, facilitated by peer mentors and / or OH staff.	Development of trauma-informed educational / experiential workshop using ideas and materials from sessions 1-4.	√	√
Some people may need more support after the Treatment Programme has been completed, if improvement in symptoms decays over time.	Make programme longer.	Development of asset-building peer support Base Group using format from sessions 5-12.	√	√
Some people may not understand the concept of self-help and may expect a “miracle cure” without making an active effort to change; some significant others may not know how best to support the person with depression.	Involve people who provide support / carers more (e.g. professional and personal).	Invite carers to attend educational / experiential workshop sessions with / without person with depression.		√
Some people may be triggered by confrontational or challenging feedback if it	Use compassionate feedback to improve awareness of how one’s behaviour impacts	Emphasise non-blaming approach understanding how people react		√

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disconfirms their core beliefs.	on others.	automatically with perceived threat if they have experienced trauma, i.e., maladaptive personal and inter-personal coping styles.		
All of the clients had experienced childhood trauma and may have had traits of personality disorder.	Need more information on how trauma affects people, and what they can do to cope with triggers.	Screen for trauma and traits of personality disorder at baseline to identify potential triggers in the 1:1 and group settings.	√	√

Mental Health and Social Inclusion