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ALIGNMENT OF WORKPLACE WELLBEING INITIATIVES WITH WHO'S "GUIDELINES FOR MENTAL HEALTH AT WORK": A SECONDARY DATA ANALYSIS FROM THREE YEARS OF THE PANDEMIC

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ABSTRACT

The workplace offers an ideal setting for promoting health and well-being. The World Health Organisation (WHO) has recently published guidelines and recommendations for promoting mental health and well-being in the workplace based on the latest empirical evidence. However, little is known regarding its alignment with current practices within organisations. The purpose of this paper is to explore the extent to which mental health and well-being initiatives implemented in organisations outside the context of a formal research evaluation align with the WHO Guidelines for Mental Health at Work. Other objectives of the study are to identify trends within current initiatives and to explore whether the number or types of initiatives align with the WHO Guidelines, depending on the size of the organisation. The study used a secondary data analysis approach for a series of case studies collected over a three-year period (2020 to 2022). A total of 333 well-being initiatives from 52 Polish and international organisations were described. The results show a wide variety of initiatives undertaken by organisations, most of which are universal individual intervention types and are implemented by large organisations. A discussion of the strengths, gaps, and opportunities for future implementation and subsequent alignment with the latest evidence-based recommendations is provided.

KEYWORDS: *WHO Guidelines, mental health, intervention, work-related stress, well-being*

1. INTRODUCTION

The workplace provides both a strategic and critical context for promoting health and well-being (Hymel et al., 2011). Organisations often experience the challenge of selecting, funding, implementing, and evaluating initiatives to promote and protect the health and well-being of their staff. Responsibility in this regard is often spread across different departments and staff within an organisation, from human resource management to occupational health and safety departments to different levels of management, with the development of clearly defined competencies of responsible professions remaining elusive (Leitão &

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Greiner, 2017; Pryor et al., 2019).

To facilitate and coordinate efforts within organisations, numerous theoretical frameworks, practical guidelines, and policy documents have emerged in recent decades within academia, governments and non-profits, and private companies in a variety of disciplines both regionally and internationally (Suran, 2022; US Surgeon General, 2022; World Health Organization & Burton, 2010). However, organisations continue to suffer from gaps in coverage, capacity or implementation of effective health promotion programmes (Jain et al., 2021). As a result, the size and scope of the challenge within organisations continues to expand. Throughout, there have been persistent calls for coordinated national and international policies related to the protection and promotion of workers' physical and mental health and well-being (Jain et al., 2022). International standards to date have focused on the development of formal occupational health and safety management systems broadly (International Organization for Standardization, 45001:2018) or with an emphasis on the management of psychosocial risks (International Organization for Standardization, 45001:2021). However, initiatives to promote mental health in the workplace and prevent mental illness continue to lag behind (World Health Organization, 2021).

Recently, the World Health Organisation commissioned the development of guidelines on mental health at work (World Health Organization, 2022). The comprehensive guidelines considered all current evidence on the prevention, protection, promotion, and support of workers' mental health and well-being. The guidelines aim to provide organisations with a framework to guide them as they "seek to improve the implementation of evidence-based interventions for mental health at work" (World Health Organization, 2022). To achieve this aim, the guidelines provide a set of 12 evidence-based recommendations across six categories of interventions that can be implemented to better promote and protect mental health and well-being at work. The six categories of recommendations include 1) organisational interventions, 2) manager training, 3) training for workers, 4) individual interventions, 5) return-to-work after absences related to mental health conditions, and 6) entry into employment for people living with mental health conditions.

For each of the 12 recommendations, additional analysis was conducted to assess their relative strength and enforceability: "the certainty of the evidence; the balance between desirable and undesirable effects; values and preferences of beneficiaries; resource requirements and cost-effectiveness; health equity, equality, and discrimination; feasibility; human rights; and sociocultural acceptability" (World Health Organization, 2022). As a result, recommendations were either rated as either 'conditional' or 'strong', with the supporting certainty of the evidence being rated as either 'very low', 'low', or 'moderate'.

While the WHO guidelines on mental health at work are based on the latest empirical evidence and rely heavily on published, peer-reviewed literature, less is known about the scope and breadth of initiatives that are regularly implemented outside the scope of formal research evaluation. Moreover, the extent to which the WHO guidelines align with the current scope of initiatives being implemented in practice at present in living organisations is relatively unknown. Identifying gaps in current practice and the WHO guidelines will also provide information on implementation opportunities and encourage broader uptake and evaluation. The aim of this paper is, therefore, to explore the extent to which current mental health and well-being initiatives align with the current recommendations as outlined by the WHO Guidelines for Mental Health at Work. To accomplish this aim, the objectives are four-fold:

1. to map the scope of current well-being initiatives across a sample of national and multinational organisations;
2. to evaluate the extent to which current well-being initiatives align with the WHO Guidelines for Mental Health at Work recommendations;
3. to identify trends within current initiatives, including strengths, gaps, and opportunities for future implementation and subsequent alignment with the latest evidence-based recommendations; and,
4. to explore whether the number or types of initiatives in alignment with the WHO Guidelines depends on the size of the organisation.

2. METHODS

2.1.Study Design

An analysis of secondary data from the organisations was conducted and is described below. Organisations of all sizes and sectors in Poland were invited to voluntarily participate in an open competition for the best well-being practices. This competition is organised annually by the Well-being Institute Ltd, one of Poland's largest and most popular consulting organisations dedicated to the education and promotion of well-being practices (cf. Molek-Winiarska and Pelc, 2022). The rationale for self-selected, rather than random, practices sampling in this study was underpinned by its focus on tracing types of initiatives that the companies

considered to be "good practice," or at least routine, rather than an example of failures or lack of any activities. Since only about 20-30% of all organizations engage in mental health and well-being activities (ESENER 2019; Molek-Winiarska and Molek-Kozakowska, 2020), we were not interested in surveying and screening random samples of organisations, but rather in restricting this variability to companies that are already aware of and committed to promoting well-being at work, in order to map the "good" initiatives and compare them with WHO guidelines.

2.2.Data Collection

The Institute has undertaken a widespread campaign using media and direct invitation letters to more than 4,000 companies included in its customer database. A wide range of companies were invited, varying in size and sector. The competition has been held annually since 2020.

Data was collected and analysed in three time periods – at the beginning of 2021, where practices undertaken in 2020 were examined (mainly initiatives implemented at the beginning of the pandemic during the first lockdown period). The second enrolment concerning practices implemented in 2021 was captured in March 2022, and the third in January 2023 included 2022 practices. Each time, companies were required to describe their initiatives in detail using a standardised questionnaire and to send it in along with additional materials such as a short presentation of the initiatives and a description of the impact. The questionnaire contained ten open-ended questions concerning the type of the initiative, well-being measurement, implementation procedures, and the level of cooperation with participants (see Molek-Winiarska & Pelc, 2022). Below are the questions included in the questionnaire:

1) *Did the company measure well-being, defined broadly as health, well-being, and balance? If yes, please justify and attach evidence. What was measured? How was it measured?*
2) *Did the company survey employees' needs and opinions before implementing the initiative? If yes, please justify and attach evidence. What was surveyed? How was it conducted?*
3) *Did the company discuss the results of the diagnostic and proposed solutions with employees? Please justify and attach evidence.*
4) *Was a formal action plan created: deadlines, timeline, communication, responsible persons, types of activities? Please justify and attach evidence.*
5) *Were the key performance indicators (KPIs) established? If yes, please justify and attach evidence. What were the KPIs?*
6) *Were the ongoing effects of the project monitored during implementation? Justify and attach evidence.*
7) *Were any necessary changes made during the initiative as required by the monitoring? If yes, please justify and attach evidence. What were the changes? Or why were no changes necessary?*
8) *Was effectiveness measured after project implementation? Please justify and attach evidence.*
9) *Was the level of well-being assessed after the project was completed? What was the result? Please justify and attach evidence.*
10) *Were conclusions and considerations made for the future? Please justify and attach evidence.*

2.3. Data Analysis

Each initiative was thoroughly analysed based on the responses from the questionnaire sent by a representative of the organisation. The content, range, assessment methods and tools, objectives, and KPIs were analysed and unified to the standardised forms to allow comparisons between the described activities. All initiatives reported by organisations were classified into one of six categories and 12 recommendations, depending on their content and using the WHO Guidelines for Mental Health at Work. This process was initially completed by one author (CL) and verified by a second author (DM-W). Any disagreements were resolved through a consensus discussion among all three authors. Broadly speaking, the classification of the initiatives fell into one of the following six categories:

1. Organisational interventions include those that target work-related psychosocial risks and are "planned actions that directly target working conditions with the aim of preventing deterioration in mental health, physical health, quality of life and work-related outcomes of workers" (World Health Organization, 2022). Organisational interventions tend to focus on primary and secondary prevention, but may also include tertiary-level prevention initiatives.
2. Manager training interventions are those that target workers in supervisory roles and aim to improve their ability to protect and support the mental health and well-being of their direct reports.
3. Worker training interventions are those that seek to support workers through increased awareness and knowledge of mental health.
4. Individual interventions include all initiatives delivered directly to a worker. These initiatives can be diverse and "include psychosocial interventions (i.e., interventions that use a psychological,

behavioural or social approach, or a combination of these) and leisure-based physical activities such as exercise (not physical labour as a part of work)" (World Health Organization, 2022).
5. Return-to-work programmes include coordinated efforts designed to "support workers in a meaningful return to work and in reducing the symptoms of mental ill-health following periods of absence" (World Health Organization, 2022).
6. Gaining employment programmes include initiatives aimed at helping people with mental illness enter the paid workforce.

Each initiative was also classified into one of the following 12 specific recommendations, as shown in Table 1.

TABLE 1. Classification system for mapping well-being initiatives, adapted from WHO, 2022.

Recommendation category	Recommendation name	Description	Strength of recommendation and level of certainty of evidence
Organisational interventions	Universal organisational interventions	Activities that "address psychosocial risk factors, including interventions involving participatory approaches, may be considered for workers to reduce emotional distress and improve work-related outcomes" (p.xi)	Conditional, very low
	Organisational interventions for health, humanitarian, and emergency workers	Activities that address the activities as above for health, humanitarian, and emergency workers.	Conditional, very low
	Organisational interventions for workers with mental health conditions	Activities include "reasonable work accommodations...for workers with mental health conditions" (p.xi)	Strong, very low-certainty
Training managers	Manager training for mental health	Activities including "Training managers to support their workers' mental health should be delivered to improve managers' knowledge, attitudes and behaviours for mental health and to improve workers' help-seeking behaviours" (p.xi)	Strong, moderate-certainty
	Manager training for health, humanitarian, and emergency workers	Activities as above to support the mental health of humanitarian and emergency workers.	Strong, moderate-certainty
Training workers	Training workers in Mental health literacy and awareness	Activities which include training workers to improve trainees' mental health-related knowledge and attitudes at work	Conditional, very low-certainty
	Training for health, humanitarian, and emergency workers	Activities as described above and as delivered to health, humanitarian, and emergency workers.	Conditional, very low-certainty

Individual interventions	Universal individual interventions	Divided into two parts: a) those delivered that aim to build workers' skills in stress management – such as interventions based on mindfulness or cognitive behavioural approaches" (p.xi), and b) activities that provide opportunities for leisure-based physical activity.	A) Conditional, low-certainty; B) conditional, very low-certainty
	Individual interventions for health, humanitarian, and emergency workers	As described above, and offered to health, humanitarian, and emergency workers.	Conditional, low-certainty
	Individual interventions for workers with emotional distress	As described under 'universal individual interventions' but delivered for workers with emotional distress.	A) conditional, very low-certainty B) conditional, very low-certainty
Return to work	Returning to work after an absence related to mental health conditions	Activities that include "(a) work-directed care plus evidence-based mental health clinical care or (b) evidence-based mental health clinical care alone" (p.xii)	Conditional, low-certainty
Gaining employment	Gaining employment for people living with mental health conditions	Activities which include "Recovery-oriented strategies enhancing vocational and economic inclusion" (p.xii)	Strong, low-certainty

3. RESULTS

Across all three time points within the current data collection period, 333 well-being initiatives were described by 7 Polish and 45 international organisations that operate in Poland. A total of 57 initiatives were reported in 2020, 176 in 2021, and 100 in 2022. The number of organisations participating in the best well-being practices competition remained relatively constant across the three waves of data collection: 18 in 2020, 19 in 2021, and 15 in 2022. A total of 33 (63%) were large organisations, 16 (31%) were medium-sized, and 3 (6%) were small. They represented a variety of sectors, including healthcare, ICT, finance and banking, manufacturing, and retail. Their countries of origin were France (19%), the United States (13%), Poland (13%), the United Kingdom (12%), the Netherlands (10%), Germany and Sweden (6% each), Luxembourg, Australia, Thailand, Hong Kong, and Denmark (4% each) and India (2%). Table 2 presents the number of initiatives undertaken each year depending on the size of the organisation.

The number and frequency of initiatives implemented in each company varied. The mean was six initiatives per company, with some companies implemented only one initiative, and up to 11 actions within a single company were implemented during the preceding year. A total of 246 (74%) of the initia-

TABLE 2. Number of initiatives by the size of the organisation over time

	Number of initiatives			
Organisation Size	**2020**	**2021**	**2022**	**Total**
Small (1-49)	1	3	1	5
Medium-sized (50-249)	14	34	14	62
Large (250+)	42	139	85	266
Total	**57**	**176**	**100**	**333**

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TABLE 3. Frequency of initiatives by WHO recommended categories over time

WHO Intervention Category	2020	2021	2022	Total
Organisational interventions	14	6	16	**36**
Manager training	0	9	2	**11**
Training for workers	2	6	9	**17**
Individual interventions	40	155	73	**268**
Return-to-work	0	0	0	**0**
Gaining employment	0	0	0	**0**
Other	1	0	0	**1**
Total	**57**	**176**	**100**	**333**

tives were short-term (3 months or shorter), and 87 (26%) were long-term initiatives (longer than three months or ongoing). Long-term initiatives were most frequently reported in 2022.

The results of the main analyses devoted to the comparison of WHO guidelines for mental health interventions and initiatives from practice indicate that the overwhelming majority of activities are individual intervention types. This trend is visible across all three years. Table 3 shows the distribution of all initiatives in terms of intervention categories proposed by the WHO.

Based on the 12 WHO recommendations described in the previous section, all initiatives were classified and distributed, as shown in Table 4.

TABLE 4. Distribution of initiatives in terms of the year and recommendation alignment.

WHO Guidelines Recommendation Alignment	2020	2021	2022	Total
1. Universal organisational interventions	14	6	16	36
2. Organisational interventions for health, humanitarian and emergency workers	0	0	0	0
3. Organisational interventions for workers with mental health conditions	0	0	0	0
4. Manager training for mental health	0	9	2	11
5. Manager training for health, humanitarian and emergency workers	0	0	0	0
6. Training for workers in mental health literacy and awareness	2	6	9	17
7. Training for health, humanitarian, and emergency workers in mental health literacy and awareness	0	0	0	0
8A. Universal individual interventions A	11	36	8	55
8B. Universal individual interventions B	25	94	42	161
9. Individual interventions for health, humanitarian, and emergency workers	0	0	0	0
10A. Individual interventions for workers with emotional distress A	4	25	23	52
10B. Individual interventions for workers with emotional distress B	0	0	0	0
11. Returning to work after absence associated with mental health conditions	0	0	0	0
12. Gaining employment for people living with mental health conditions	0	0	0	0
13. Other	1	0	0	1
Total	**57**	**176**	**100**	**333**

There was a notable variety of initiatives undertaken by organisations. Some of them were quite common and were implemented in most companies. However, there were also very creative and "peculiar" initiatives such as renting apartments at the seaside for employees to work and/or rest with their families - to promote well-being or meetings with famous sports stars to increase motivation and "positive spirit" in times of pandemic and lockdowns. In addition, the vast majority of organisational-level interventions were at the primary level of prevention, while most individual-level intervention activities were found to be aligned with secondary and tertiary levels of prevention. Table 5 describes some of the most common initiatives implemented at the prevention level.

TABLE 5. Examples of interventions undertaken in the analysed organisations

Type of intervention	Individual level	Organisational level
Primary	• Promoting physical activity and a healthy lifestyle (webinars, podcasts, workshops, individual meetings with trainers, dieticians, physicians, physiotherapists, and other sport experts) • Supporting mental health (webinars, health coaching, psychological counselling, workshops, meetings with psychologists, psychiatrists, therapists) • Supporting work-life balance (workshops, webinars, meetings on specific aspects of work-life balance) • Sponsoring integration events and team-building activities • Launching educational platforms on health (mental, physical) and well-being (organisational, individual, social)	• Providing preventive medical care and group insurance • Maintaining favourable psychosocial working conditions, creating spaces for resting (chill-our rooms, green offices, etc.) • Maintaining flexitime and adequate work schedule • Creating a work environment supporting the development and lifelong learning
Secondary	• Informal integration meetings to build/restore employee support • Stress reduction training, mindfulness, meditation, relaxation training, workshops, courses • Physical exercises workshops, meetings • Mental resistance support • Social and interpersonal skills training • Sports competitions • First aid training, pre-medical aid training • Stress management training for managers	• Improving communication processes • Building a healthy and supportive organisational culture • Creating space for physical activity • Furnishing home offices and taking care of ergonomics of workstations of home offices • Funding for co-financing home office labour costs • Financial counselling, salary adjustments related to inflation • Financial support for sports teams
Tertiary	• Sessions with a psychologist, dietary expert, physical therapist • Individual therapies, hotlines – psychiatric/psychological assistance • Psychiatric support • Health monitoring sensors/apps	• Granting sabbaticals • Reducing working days/hours due to prolonged sitting or work-life imbalance

4. DISCUSSION

The current project sought to be the first to explore the extent to which current workplace well-being initiatives align with the recommendations outlined by the WHO's Guidelines for Mental Health at Work. To accomplish this aim, we mapped 333 initiatives from 52 national and international organisations operating in Poland over a three-year period.

It was found that the organisations surveyed most often reach for quick solutions that are relatively easy to deliver. They usually respond to the reported needs of employees in the field of well-being. These initiatives can be easily implemented and achieve results that match established KPIs relatively quickly (Cox et al., 2000). Thus, organisations follow three main reasons for implementing individual initiatives more often than organisational, described by Houtman (2007):

- the opinion that mental problems arise from difficulties in coping with stress and the individual psychological resilience of the employee, not from the organisational environment;
- it is not in the interest of the organisation to make major systemic changes to reduce stress and improve well-being; and,
- it is much easier to implement an individual intervention while maintaining a reasonable standard of quality than to undertake comprehensive and complicated initiatives at the organisational level.

Regarding the second objective, results show a significant gap between the recommendations from the WHO and the initiatives most frequently implemented in organisations. While the WHO rates individual interventions as having very low certainty of evidence and recommends focusing on manager training for mental health (strong recommendation and moderate certainty of evidence), organisations mainly implement individual interventions and additionally short-term ones. The most common reasons for such actions are employee requests and suggestions. According to the analyses, these initiatives meet the needs of employees and often lead to better subjective well-being and a reduced desire to leave the organisation. Only a few organisations have taken actions to train managers in stress management and increase their awareness of mental health. These initiatives mainly took place in 2021 and 2022. It may suggest increasing awareness in terms of stress reduction of the employees by increasing managerial skills. However, these rare initiatives were not evaluated by any organisation as separate activities. Therefore, it is not known whether these initiatives or others all together contributed to the promotion of well-being.

In terms of other trends identified in the mapping exercise of current initiatives, it is noteworthy that almost half of all initiatives (161 out of 333) were classified as universal individual interventions for leisure-time physical activity (aerobic training, walking, yoga). Furthermore, this trend has remained stable over three years. It can be explained by the organisation meeting the needs of employees who had experienced a decrease in physical well-being caused by a lack of or limited physical activity (gym closures, restrictions), musculoskeletal ailments, weight gain, and general fatigue and weakness. It also appears that such initiatives are quite easy to implement and assess their effectiveness in terms of satisfaction and needs fulfilment. Therefore, organisations eagerly implemented various activities related to physical activity – individual or group, with or without a trainer, online or outdoors. It was observed that in some instances, organisations simply sponsored such activities, whereas, in others, they initiated and organised them during or after business hours. Overall, these initiatives were reported to have contributed to building the overall impression of satisfaction and improve physical well-being without the need for a more in-depth evaluation of evidence-based effectiveness.

Organisations did not report investing considerable time or resources in sourcing the latest evidence-based interventions to promote or protect the mental health of their employees. In addition, their reported evaluations of the effectiveness of the initiatives appear to be fairly superficial, with less emphasis placed on building a solid evidence base with multiple outcomes such as a decrease in absenteeism or presenteeism, reduced accident rates or employee turnover, or an increase in productivity. Instead, there appears to be a reliance on subjective evaluations and feedback from employees on their enjoyment of participation to ultimately determine the success of the initiative.

Regarding the last objective of the paper, the conducted research shows that the fewest well-being initiatives were implemented by small companies (Table 1). In terms of the size of the companies that participated in the competition organised by the Well-being Institute Ltd, it was the least popular among small companies. Of course, it can be assumed that they implement various initiatives to promote the mental health of their employees, but there are external factors that precluded them from participating in such competitions (e.g., interest, capacity, awareness). The pandemic was particularly challenging for small and medium-sized enterprises (SMEs), and their attention and resources were focused on achieving other goals.

The reason for this state of affairs is more complex. It is based on the fact, discussed in the literature, that SMEs are a neglected sector in occupational health research and practice (Dawkins et al., 2018; Martin et al., 2009). However, this sector is the most common work environment in most economies, and they are not exempt from unique challenges related to mental health issues (Cocker et al., 2013). It is very likely that managers and employees struggle with mental health issues of different natures, but they are not identified; they are often disregarded and pushed to the background. There needs to be more awareness, knowledge, human resources, tools, and solutions for promoting and protecting mental health adapted to the real needs of SMEs (Torres and Benzari, 2021; Hogg et al., 2021).

5. RECOMMENDATIONS

Based on the study results, it is recommended that researchers and supporting organisations alike take an integrated approach that disseminates instruments to assist organisations in implementing workplace mental health (WMH) programs (Nebbs et al., 2023). In addition, it is important to provide recommendations for workplace mental health interventions tailored to the specifics of small and medium-sized enterprises (SMEs), as they require special attention (Arensman et al., 2022; De Angelis et al., 2020).

The implementation of individual interventions in conjunction with organisational and managerial interventions is crucial to increase their effectiveness and adoption. In line with the WHO's guidelines and the current level of evidence, it is recommended that organisations expand their initiatives to train both managers and workers on their knowledge, attitudes, and behaviours related to mental health and well-being. In addition, it is recommended that managers increase mindfulness and implement organisational-level guidelines on mental health issues, including support for employees affected by mental health issues. By following these recommendations, organisations can promote mental health and create a mentally healthy work environment.

6. STRENGTHS AND LIMITATIONS

The strengths of this article are evident in the diverse range of organisations represented, which reported comprehensively and authentically on their initiatives and reflected their views on current best practices or promoting mental health and well-being. This provided an opportunity to gain insight into a variety of perspectives and approaches to the subject matter. However, the limitations of the current approach are that the information provided is self-reported, and the organisations may have selected initiatives that present them in a favourable light. Therefore, it is important to look critically at the information and acknowledge potential biases and limitations in the data presented.

7. CONCLUSION

Organisations often implement initiatives to improve the well-being of their staff, but there is a slight gap between the prevalence and weighting of these initiatives and the best practices recommended by the WHO Guidelines. To bridge this gap, organisations are encouraged to empower their employees and managers through training, for which there is still a stronger evidence base. It is recommended that organisations work collaboratively with researchers to conduct methodologically rigorous studies on both individual and organizational-level interventions. Finally, it was observed that large organisations continue to implement a plethora of well-being initiatives, whereas SMEs continue to lag behind.

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USKLAĐENOST INICIJATIVA ZA DOBROBIT NA RADNOM MJESTU S WHO-OVIM "SMJERNICAMA ZA MENTALNO ZDRAVLJE NA RADU": SEKUNDARNA ANALIZA PODATAKA KROZ TRI GODINE PANDEMIJE

SAŽETAK

Radno mjesto pruža idealno okruženje za promociju zdravlja i dobrobiti. Svjetska zdravstvena organizacija (WHO) nedavno je objavila smjernice i preporuke za promociju mentalnog zdravlja i dobrobiti na radnom mjestu temeljene na najnovijim empirijskim dokazima. Međutim, malo se zna o njihovoj usklađenosti s trenutačnim praksama unutar organizacija. Svrha ovog rada je istražiti do koje mjere se inicijative za mentalno zdravlje i dobrobit provedene u organizacijama izvan konteksta formalne istraživačke evaluacije usklađuju s WHO-ovim smjernicama za mentalno zdravlje na radu. Ostali ciljevi istraživanja su identificirati trendove unutar trenutačnih inicijativa i istražiti usklađuju li se broj ili vrste inicijativa s WHO-ovim smjernicama, ovisno o veličini organizacije. Studija je koristila sekundarnu analizu podataka za niz studija slučaja prikupljenih tijekom trogodišnjeg razdoblja (2020. do 2022.). Ukupno je opisano 333 inicijative za dobrobit iz 52 organizacije u Poljskoj i u međunarodnom okruženju. Rezultati pokazuju širok spektar organizacijskih inicijativa, od kojih su većina univerzalne individualne intervencije, a provode ih velike organizacije. Raspravlja se o prednostima, prazninama i mogućnostima za buduću implementaciju te naknadno usklađivanje s najnovijim preporukama temeljenim na dokazima.

KLJUČNE RIJEČI: *WHO smjernice, mentalno zdravlje, intervencija, stres povezan s radom, dobrobit*