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An exploration of mental health and well-being workplace practices within family firms

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An exploration of mental health and well-being workplace practices within family firms

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ABSTRACT

This paper explores the workplace practices that family-owned firms adopt to support mental health & well-being and reduce work-related risk factors. Guided by our novel dataset from the Enterprise Research Centre (ERC) Mental Health and Productivity survey on firms in England that reflects pre, during, and post-COVID-19 pandemic, a descriptive analysis is presented. This analysis offers the first insight into family and nonfamily firms' behaviour towards, and experiences of, managing mental health & well-being. Some trends are common across both family and nonfamily firms: most firms (family & nonfamily) measure and monitor sickness absence with the proportion of both family and nonfamily firms reporting mental health sickness-related absence falling then bouncing back during the pandemic. Differences are also observed, however: while the proportion of both family and nonfamily firms engaging in activities to improve workplace mental health has increased during the pandemic these activities are notably less common among family firms. The lower uptake of mental health-related activities in family firms appears to be linked to financial constraints, as family firms are more likely to have adopted activities that do not require a financial investment. This initial analysis suggests some directions for future research.

1.INTRODUCTION

There is limited research on mental health and well-being studies in the family firm literature (Arijs and Michiels, 2021). Therefore, this paper addresses the research gap by exploring the workplace practices that family-owned firms adopt to support mental health and well-being. There is strong international evidence of the large economic cost to employers of poor mental health (Bubonya, Cobb-Clark, and Wooden, 2017; Lecours, St-Hilaire and Daneau, 2021; Deloitte, 2022). These costs have increased by 25 percent since 2019 in the UK (Deloitte, 2022) and reached an estimated annual total cost of £53-56 billion in 2020-21. During this time, the COVID-19 pandemic brought about many challenges that required employers and employees to quickly adapt and respond to changing workplace environments, affecting mental well-being (Beckstein *et al.*, 2022). Employers play a critical role in addressing mental health problems, developing employment policies, providing a supportive workplace culture (Bubonya, Cobb-Clark and Wooden, 2017), and striving for a healthy workplace (Ipsen, Karanika-Murray and Nardelli, 2020).

With mental health integrated into the UN's Sustainable Development Goals (SDGs) in 2015, it has received increased global recognition. Mental health conditions (including stress, depression, anxiety, and serious mental health problems) are one of the reasons for sickness absence in the UK labour market (Office for National Statistics, 2021) and are attributed to a loss in productivity in organisations (Johns, 2010; Lecours, St-Hilaire and Daneau, 2021). The economic cost of mental health stems from workers' reduced productivity, which can be measured in terms of absenteeism, presenteeism (attending work while ill), and staff turnover (Bubonya, Cobb-Clark and Wooden, 2017). To reduce the severity of stress and mental health at work, research has suggested focusing on the work environment, working conditions, and leadership (Kuoppala *et al.*, 2008; Lecours, St-Hilaire and Daneau, 2021). Workplace health promotion practitioners have the opportunity to focus on understanding and supporting employee mental health (Attridge, 2019).

Our paper contributes to this gap as it focuses on identifying the workplace practices that family firms adopt to support mental health and well-being and reduce work-related risk factors. Acknowledgment of and response to mental health concerns has improved with the development of best practices for work-related mental health. In organisations, leadership is important as managers act as gatekeepers supporting employees' mental health (Asare-Doku *et al.*, 2022) and are drivers of organizational change (Dimoff and Kelloway, 2019a). For instance, leaders who engage in workplace training intervention

positively influence both leader and employee behaviour around mental health (Dimoff and Kelloway, 2019b). Mental health management programs and mental health training for managers can lead to positive "returns-on-investment (ROI), increased mental health literacy, and improvements in employee resource use (Dimoff and Kelloway, 2019a). Yet while studies demonstrate that employers are cognizant of the benefits of mentally healthy workers, they remain uncertain about the corporate responsibility to provide mental health care for employees (Pescud *et al.*, 2015).

Family businesses uniquely deal with the intertwining and interdependence of family and the business system, which brings forth different challenges and opportunities compared to non-family businesses (Arijs and Michiels, 2021). The ownership structure enables firms to make rapid decisions and respond to changes quickly (Carney, 2005). Given the limited studies on mental health in family businesses, more research is needed to better understand the challenges that family businesses faced with managing mental health, and the support for mental health well-being (Arijs and Michiels, 2021)

In this paper, the analysis is based on a novel data source. The ERC Mental Health and Productivity survey (Wishart *et al.*, 2021) data on UK firms (c. 5,354) provides detailed information on firms' management of mental health and well-being in the workplace. Guided by our novel dataset that reflects the pre, during, and post-COVID-19 pandemic, a descriptive analysis is presented. This analysis compares the support for workplace mental health in family and nonfamily firms across three years (2020, 2021, 2022) in a time of increasing uncertainty and disruption in the workplace due to the global pandemic. We also extend this comparison to include firm size and sector.

The findings of this paper suggest that all firms (family and nonfamily) report that sickness absence impacts the performance of their business. The proportion of firms reporting long-term sickness and repeated sickness has returned to pre-pandemic levels, having declined during the pandemic. Over the three years, we see changes in work practices with the proportion of firms reporting presenteeism in the workplace to have fallen since the pandemic. Absenteeism and presenteeism reported figures are similar for family and nonfamily-owned firms.

The proportion of firms reporting mental health-related sickness absence has falling then bouncing back during the pandemic. The proportion of firms currently offering mental health initiatives has increased indicating growing engagement with mental health issues at the firm level. However, we observe that a higher proportion of nonfamily firms support mental

health initiatives than compared to family firms. The lower uptake is due to financial constraints, as firms are more likely to have adopted approaches that did not require additional funding.

The argument is developed as follows. Section 2 outlines the literature on mental health and the management practices for mental health in family firms. Section 3 describes our data and section 4 provides a descriptive analysis of the results. Section 5 presents the next steps for the development of this paper.

2. LITERATURE REVIEW

2.1 Mental Health & Family Firms

Mental health is defined as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (World Health Organization, 2018). Given the prevalence of mental health issues, the management of mental health in the workplace is of significant social, and economic concern (OECD, 2021). The worldwide burden of poor mental health translates to costly diseases that impact local, national, and global economies. Approximately, between $150 and $300 billion is lost each year in the United States due to mental illness, and similar losses are experienced in Canada and Europe (Dimoff and Kelloway, 2019a). These economic costs have piqued the interest of government agencies, insurance providers, and private and public organisations.

The COVID-19 pandemic has increased the mental health problems of the global population with "higher than normal levels of depression, anxiety, distress and insomnia have been reported since the outbreak" (T. Wu *et al.*, 2021). Aside from the direct costs, the indirect costs are related to lost productivity from presenteeism, absenteeism, and staff turnover. Therefore interventions are needed for preventing mental health issues (T. Wu *et al.*, 2021). The OECD strives for an integrated approach to developing its policies on mental health[1].

[1]Common mental health problems can include stress, anxiety, and depression. In the US mental illness such as depression costs the economy €210.5bn, with approximately half being paid by employers (A. Wu et al., 2021). Beyond the direct costs, the indirect costs relate to lost productivity from both absenteeism and presenteeism. In Canada alone 500,000 workers each week are absence from work due to related mental health concerns (Lecours, St-Hilaire and Daneau, 2021).

The pandemic has taken a global dimension and led to myriad challenges confronting businesses, threatening the survival of firms (Kraus *et al.*, 2020; Amore, Quarato and Pelucco, 2021). This led to particularly salient challenges for family businesses (De Massis and Rondi, 2020; Firfiray and Gomez-Mejia, 2021) as they made tough business decisions such as cost-cutting measures, closure of businesses, and layoffs (Kraus *et al.*, 2020). Family firms tend to follow different approaches to dealing with a crisis (De Massis and Rondi, 2020), leading to the resilient performance of the family businesses (KPMG/STEPS, 2021). Indeed, leadership and succession planning are top priorities in the family business during times of crisis and uncertainty (Firfiray and Gomez-Mejia, 2021).

The unique juxtaposition of family and business in their organizational structure makes family businesses different from their nonfamily counterparts. The owning family has to juggle the needs of the family and the business system, which often can overlap. “The behaviors of family firms are affected by both the imprinting of the family and firm and environmental pressures for conformity and change (Sharma *et al.*, 2020)”. Family businesses have a unique bundle of adaptive resources and challenges, such as long-term orientation, socioemotional wealth and shared family values, compared with non-family businesses (Miller, Wiklund and Yu, 2020). The pressures to respond to this pandemic has affected family firms’ ability to preserve their socioemotional wealth (Firfiray and Gomez-Mejia, 2021), which can influence, as well as reduce the severity of mental disorders (Miller, Wiklund and Yu, 2020).

In addition, family firms possess certain attributes such as family control, identity, and generational succession which differentiate them from non-family firms (Firfiray and Gomez-Mejia, 2021). Family control allows them to create an adaptive environment to support family employees with mental disorders (Miller, Wiklund and Yu, 2020). Family firms adapt structures, and processes, while responding to the needs of employees with mental disorders (Miller, Wiklund and Yu, 2020).

2.2 Unique characteristics of family firms

Family firms differ from non-family businesses when the family and business resources become intertwined (Chrisman, Chua and Litz, 2003). While the definition of a family firm is elusive, it can be considered a business owned and managed by members of the same family with the intent of generational succession (Chua, Chrisman and Sharma, 1999). Family firms outperform their non-family counterparts (Miller and Le Breton-Miller, 2006) due to the ‘family effect’ (Dyer, 2006) and the unique bundle of resources that allow them

to achieve competitive advantage (Habbershon and Williams, 1999), creating wealth. Other unique characteristics found in family firms such as long-term orientation (Sharma and Irving, 2005), socioemotional wealth (Gómez-Mejía *et al.*, 2007), higher aversion to risk (Poza, Alfred and Maheshwari, 1997), and shared family values influence family firm behaviours.

Family firms perform fewer innovation efforts than nonfamily firms because innovation activities are costly and risky. Family firms have limited resources, and are risk averse therefore choosing investments with lower risk which in turn yields lower returns (Aiello, Mannarino and Pupo, 2020). While family firms tend to be less profitable than nonfamily firms because of reinvesting profits back into the business, the survival and longevity of family firms are greater than that of nonfamily firms (Diéguez-Soto, López-Delgado and Rojo-Ramírez, 2015). Families intentions for transgenerational control influence short and long term family goals, leading to more heterogeneous behaviours arising in family firms than in nonfamily firms (Chrisman and Patel, 2012).

Overall, family firms are heterogeneous due to the ownership structure as the family involvement and interactions that constitute idiosyncratic resources and capabilities (Habbershon and Williams, 1999), ways of managing the company (Stewart and Hitt, 2012) and the diverging goals, missions and strategy (Lansberg, 1983) found in family firms.

2.3 Management practices among family firms

As very little is known about family firms' decisions to adopt mental health & well-being practices and initiatives (Arijs and Michiels, 2021), we first draw on previous literature which examines family firms' adoption of management practices to better understand the important determinants of their decision-making. Management practices can affect the productivity between firms and countries (Bloom, Sadun and Reenen, 2016) and the survival of firms (Bloom *et al.*, 2012). Bloom and Van Reenen, (2007) found that having better management practices enhances firm performance, productivity, profitability, sales growth, and survival. There is also an increase in energy efficiency associated with good management practices (Bloom *et al.*, 2012). The heterogeneity of behaviours across family firms (Chua *et al.*, 2012) could be associated with differences in the adoption of management practices (Bloom and Van Reenen, 2007; Tsoutsoura, 2021).

Bloom *et al.*, (2013) found that the intervention of management consulting in large family-owned Indian textile firms enhanced productivity and firm profitability as firm growth occurred due to delegation. This evidence shows the significance of these management structures, yet family firms can be slower to adopt which may explain the differences between family and non-family firm performance (Bloom *et al.*, 2013).

Based on operational practices such as improved monitoring, targets driven and incentives, Bloom et al., (2012) found that, founder-owned, and founder CEOs are, on average, the worst-managed firms. This may be associated with the founders' skills not being adequate to support the development and growth of the firm. Managers and workers that have the knowledge, and education can improve management performance (Bloom *et al.*, 2012).

Family-owned firms that have a professional manager usually also have good managerial practices, whereas when the firm is managed by family, particularly if the CEO is chosen by primogeniture, it can be poorly managed (Bloom and Van Reenen, 2007). A family member CEO may also have less of an understanding of the need for management structure practices (Tsoutsoura, 2021) and take up the position due to tax exemptions offered to family firms (Bloom et al., 2012). Family members may seek to maximize their socioemotional wealth rather than their financial wealth (Berrone, Cruz and Gomez-Mejia, 2012), which differs from nonfamily firms. In addition, if the family firm experiences succession, this can negatively affect the firm. This is due to the primogeniture succession rules in family firms, where the eldest son becomes CEO, irrespective of the ability which can relate to poorer management and potentially lower productivity.

The constraints as to why family firms do not adopt these management practices were considered in the (Bloom *et al.*, 2013) survey. A key reason for low adoption is due to informational constraints. Firms were unable to link the benefit of adopting new/improved management practices to boosting profitability. Aside from trying to change owners' beliefs on the efficacy of management practices, time and ability constraints also hindered the adoption. (Bloom and Van Reenen, 2007) noted that three reasons for not adopting may be associated with costs, agency considerations, and industry heterogeneity. The returns need to outweigh the costs and firms will not adopt if they have heard the adoption is not profitable enough (Bloom *et al.*, 2013).

A recent study examining the adoption of management practices among family firms reports that structured management adoption is below the 'optimal' level (Tsoutsoura, 2021).

2.4 Mental Health Workplace Interventions

Ipsen, Karanika-Murray and Nardelli, (2020) call for a deeper understanding of how leaders can integrate the management of mental health with organizational performance. The stewardship motivation of family firm leaders gives rise to encouraging positive behaviour and employee well-being, which leads to family firms experiencing higher levels of altruistic behaviour, work engagement, and job satisfaction than nonfamily firms (Ceja, Escartín and Rodríguez-Carballeira, 2012). Family firms with family management tend to increase the adoption of mutuality HRM practices[2], in comparison to non-family CEOs (Flamini, Pittino and Visintin, 2021). Good leadership improves job satisfaction and job well-being which in turn decreases sickness absenteeism (Kuoppala *et al.*, 2008). There are 'mutual gains' for both the employee and the organization and this employment relationship leads to overall enhanced performance (Lambrechts and Gnan, 2022).

There are various types of practices that firms can adopt to support work-related mental health. (A. Wu *et al.*, 2021) lists leadership support as one of the eight best practices[3] that firms could adopt to support mental health in the workplace. For instance, training for leaders that targets mental health in the workplace cultivates an environment that reduces the stigma barrier surrounding mental health (Dewa *et al.*, 2021), increasing recognition of employees' struggles and providing access to appropriate organizational resources (Dimoff and Kelloway, 2019a; Dimoff and Kelloway, 2019b), which reduces work-related sickness absence (Milligan-Saville *et al.*, (2017). It also has the potential to lead to positive ROI (Dimoff and Kelloway, 2019a).

A supportive work culture improves mental health by providing opportunities for social connectedness and self-care (A. Wu *et al.*, 2021). The worker-manager relationship is important as it encourages positive disclosure, making it easier for employers to identify employee mental health needs and allows for open communication on mental health benefits and resources (A. Wu *et al.*, 2021). This disclosure raises the need for managers and organizations to be more prepared and understanding of the needs required to address the concerns of their staff. While the workplace is an ideal setting for health promotion

[2] HRM practices influence employee well-being (job satisfaction, stress reduction and health related benefits), and therefore positively inducing the individual and organization performance (Flamini, Pittino and Visintin, 2021).
[3] The other seven practices include: "(1) culture, (2) robust mental health benefits, (3) mental health resources, (4) workplace policies and practices, (5) healthy work environment, (6) outcomes measurement, and (7) innovation" (Wu et al., 2021).

(Asare-Doku *et al.*, 2022), some firms are slow to implement best practices. For instance, Asare-Doku *et al.*, (2022) found that for mining companies, the lack of a mental health policy is due to the risk of reduced profits, insufficient resources in dealing with mental health concerns, and the disbelief regarding the benefits of mental health interventions (Asare-Doku *et al.*, 2022). Addressing and overcoming these barriers would improve productivity leading to returns for organizations (Asare-Doku *et al.*, 2022).

3. DATA

This analysis uses data from the ERC Mental Health and Productivity survey (Wishart *et al.*, 2021) data on firms in England (c. 5,354). The survey focussed on private for-profit firms, social enterprises, and organisations in the charity and voluntary sectors, excluding local government and central government funded organisations. It also excluded establishments operating for less than three years and those with less than 10 employees.

A stratified sampling approach was adopted across the East and West Midlands regions and for firm size (10-19, 20-49, 50+). Organisations with 10- 19 employees were intentionally under-sampled as they accounted for the majority of the population universe. Larger organisations were therefore over-sampled to ensure they were adequately represented.

The survey was conducted with business leaders using CATI survey analysis. Three separate waves of data (in 2020, 2021, and 2022) have been collected. In 2020, the survey was completed before the first lockdown in England in March 2020 (c. 1,899 firms), providing a pre-COVID baseline. In 2021 between January and April (c.1550 firms) the survey was repeated at the time of the 3rd national lockdown in England, a period of remote work and many more employees were on furlough. In 2022, firms (c. 1500) were re-contacted between January and April, a period after the easing of COVID-19 restrictions in England (July 2021) and the end of the furlough scheme in September 2021.

The survey explores approaches to the management of mental health and engagement with mental health activities and initiatives. It presents several key business and employee demographics, providing insights into employers' attitudes toward and support practices of mental health in the workplace.

Table 1 reports a summary of descriptive statistics for the variables used in the analyses. On average, 64 percent of firms are family owned and 83 percent of firms are family

managed (managed by a member of the family). On average 38 percent of businesses are nonfamily firms. Nearly half of firms are small businesses, employing between 10-19 employees, reflecting the dominance of this size of the firm in the business population. The sample was designed to be representative of the overall breakdown of firms by sector. Half of the firms are operating in the wholesale retail sector, and other services sectors. Of the firms surveyed, on average, they are in business for nearly 20 years.

All variable descriptions are provided in Appendix Table A1.

Table 1. Descriptive Statistics

Variable	Mean	Std. Dev.
Presenteeism	0.246	0.431
Absenteeism: Long term sickness	0.494	0.500
Total number of absence days	121.233	1583.504
Absenteeism per employee	3.063	4.500
Labour Turnover	2857.713	3366.331
Mental Health related sickness absence	0.280	0.449
Business performance impacted by mental health sickness absence	0.143	0.350
Family business	0.637	0.481
Family management	0.834	0.372
New technology	0.560	0.496
Prevention Activities		
Mental health plan	0.265	0.441
Mental health lead at board level	0.402	0.490
Mental health data	0.416	0.493
Mental health report	0.328	0.470
Mental health support	0.529	0.499
Workplace Practices		
Mental health budget	0.208	0.406
Mental health open conversation	0.949	0.220
Mental health adjustments	0.928	0.259
Mental health regular conversation	0.817	0.387
Mental health employee champion	0.363	0.481
Skills Training & Monitoring Activities		
Mental health risk assessments/stress audits	0.633	0.482
Mental health awareness for staff	0.695	0.461
Mental health training for line managers	0.491	0.500
Firm Size (10- 19)	0.487	0.500
Firm Size (20- 49)	0.327	0.469
Firm Size (50- 249)	0.164	0.371
Firm Size (250+)	0.022	0.146
Firm age	19.441	7.044
Sectors		
Production	0.132	0.338
Construction	0.047	0.211
Wholesale, retail	0.258	0.437
Hospitality	0.114	0.317
Business Services	0.190	0.392
Other services	0.260	0.439

Note: See Annex 1 for variable definitions. Observations are weighted to give representative results.

4. EXPLORING ABSENTEEISM AND PRESENTEEISM IN FAMILY FIRMS

In this section, a description of firm (family vs non-family) characteristics will be presented. It will outline firm-related mental health sickness absences, and the firm attitudes and approach towards mental health by identifying the provision of workplace mental health support activities.

4.1 Absenteeism, presenteeism, mental health sickness absences

All firms report that sickness absence impacts the performance of their business. Since the pandemic, firms that measure and monitor sickness absenteeism report that sick leave is on average 3 days per employee. The average number of sickness days has increased above pre-pandemic levels (see table 4.1a). The proportion of firms reporting long-term sickness and repeated sickness has returned to pre-pandemic levels having declined during the pandemic (see table 4.1b). This decline could have been due to businesses being temporarily closed, particularly in sectors such as hospitality and other service sector.

Table 4.1a: Absenteeism – Days absent per employee

	2020	2021	2022
Family Firms	3	2.5	3.5
Nonfamily firms	2.8	2.5	3.3
All firms	3	2.5	3.5

Base: 1899 firms in 2020, 1551 in 2021, 1904 in 2022

Table 4.1b: Absenteeism – Long term sickness and repeated sickness absence

	2020	2021	2022
Family Firms	43	37	42.8
Nonfamily firms	54.8	38.6	47.9
All firms	49	38.7	45.8

Base: 1899 firms in 2020, 1551 in 2021, 1904 in 2022

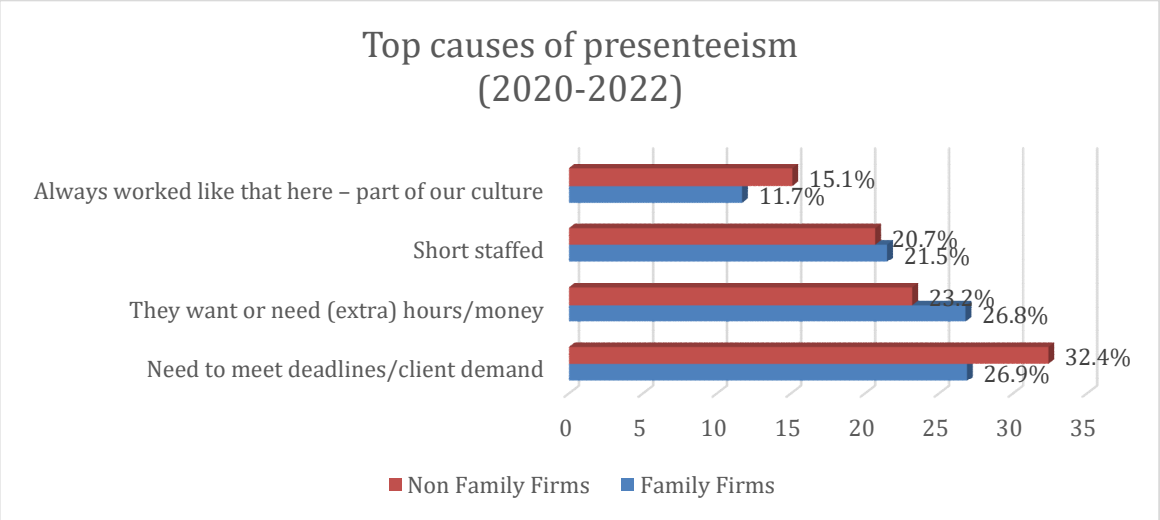
Table 4.2: Presenteeism

	2020	2021	2022
Family firms	30.3	14.9	19.3
Nonfamily firms	37.68	20.1	22.1
All firms	34.1	16.8	21.3

Base: 1899 firms in 2020, 1551 in 2021, 1904 in 2022

The proportion of firms reporting presenteeism, where workers are present in the workplace but underperforming due to ill health or working beyond their contracted hours has declined and remains below pre-pandemic levels (see table 4.2). It is likely that the reduction in presenteeism can be explained by an increase in remote working and furloughed employees due to the pandemic. The causes of presenteeism most cited by firms were the need to meet client deadlines/client demands, and then the need for extra hours (see figure 4.1a). The increase in employees seeking extra hours could be associated with the rise in the cost of living, and/or staff shortage that has increased post-pandemic due to the changing global climate. This can vary depending on firm size, with larger firms more likely to cite employees seeking extra hours/money. Smaller firms are more concerned with meeting client demand and deadlines (see figure 4.1b). In 2022, 65 percent of firms that are experiencing presenteeism are taking steps to address it. The most common action by firms is by managers sending employees home when they are unwell (see figure 4.2). The second most common response is employers investigating its potential causes (e.g. workload) and thirdly training line managers to spot signs of presenteeism. This highlights the lack of awareness of strategies for tackling presenteeism in firms.

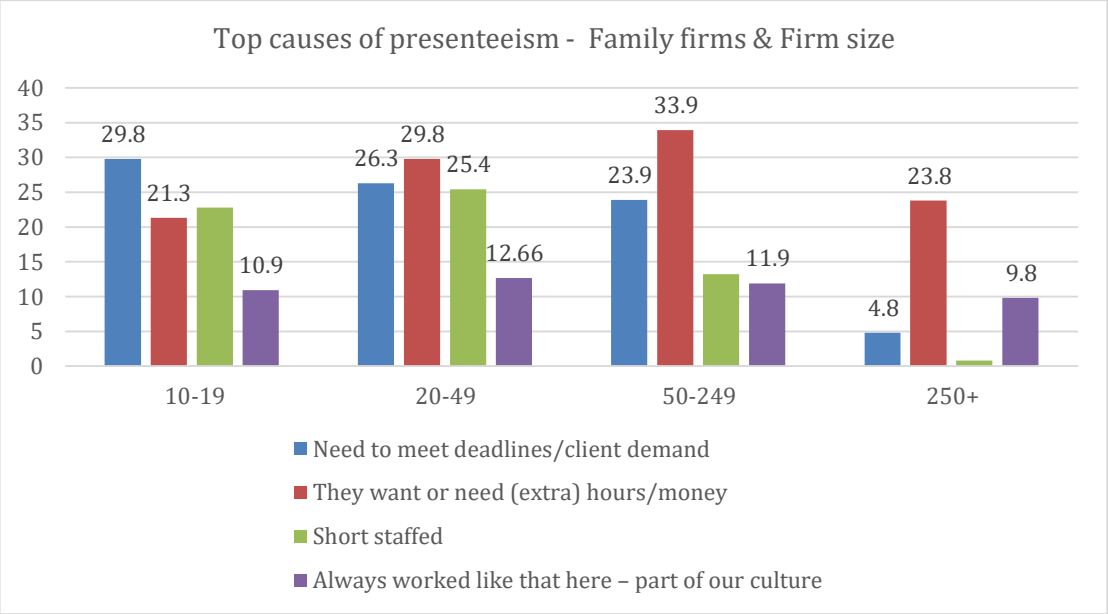
Figure 4.1a: Causes of presenteeism



Base: 673 family firms, 497 nonfamily firms

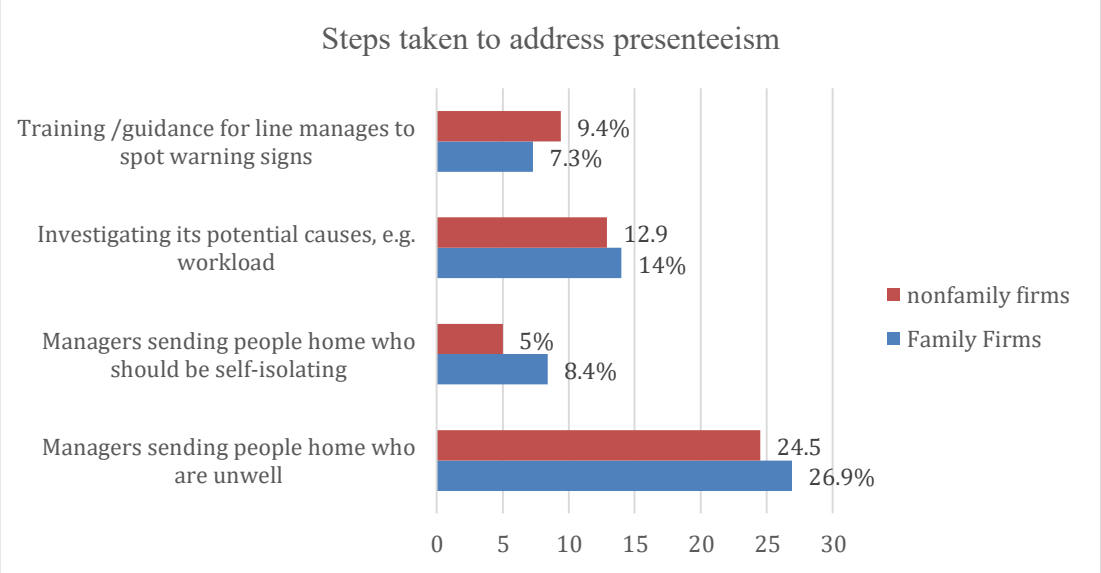
Note: Firms had to experience instances of presenteeism in the business.

Figure 4.1b: Causes of presenteeism – Family firms & firm size



Base: 1037 family firms in 2020, 920 in 2021, 1102 in 2022

Figure 4.2: Firms taking steps to address presenteeism.



Base: 1899 firms in 2020, 1551 in 2021, 1904 in 2022

The pandemic, and the shifts in working practices associated with it, have meant considerable changes in how firms experience mental health related absences. Firstly, the proportion of firms reporting that mental health-related absence impacts their business performance has fallen since the pandemic. Larger firms were the most likely to report mental health-related absence. There is a smaller proportion of firms during the pandemic that reported mental health sickness absence which is reflective of a period of extreme

turbulence driven by the COVID-19 crisis. During this time, several firms in some sectors were shut down temporarily and the proportion of employees working remotely in many firms significantly increased.

In addition, we now compare family and nonfamily firms on absenteeism, presenteeism and mental health sickness absence reported figures. Firstly, absenteeism and presenteeism reported figures are similar for family and nonfamily owned firms. Whereas, family firms experience lower levels of presenteeism for all three years in comparison to nonfamily firms. The proportion of family firms reporting presenteeism declined during COVID-19 and has remained below pre pandemic levels. For instance, in 2020, 30 percent of family firms reported presenteeism, which has fallen to 19 percent post-pandemic.

Secondly, we observe that a higher proportion of nonfamily firms compared to family firms reported mental health related absences (as seen in Table 4.3). There was some variation by sector and size of family and nonfamily firms. The proportion of firms experiencing mental health related absence is lower in the construction sector and highest among other service sectors.

Table 4.3: Proportion of firms (Family vs Nonfamily) reporting mental health sickness absence, by size and sector.

	2020	2021	2022
Family Firms	27.0%	21.4%	24.1%
Main Sector			
Production	25.7%	18.9%	22.5%
Construction	19.5%	7.7%	18.5%
Wholesale, retail	21.7%	17.9%	21.9%
Hospitality	21.6%	21.5%	18.7%
Business Services	25.9%	18.9%	26.0%
Other services	40.5%	31.8%	31.5%
Size			
10-19	13.4%	12.5%	16.8%
20-49	38.6%	22.9%	28.2%
50-249	44.8%	43.2%	40.2%
250 plus	60.2%	58.6%	74.9%

	2020	2021	2022
Nonfamily firms	33.8%	25.0%	28.8%
Main Sector			
Production	37.2%	27.4%	26.7%
Construction	25.9%	21.0%	13.9%
Wholesale, retail	31.1%	16.7%	21.2%
Hospitality	32.3%	19.8%	37.8%
Business Services	33.1%	24.6%	26.2%
Other services	38.3%	36.7%	39.2%
Size			
10-19	21.6%	12.7%	15.0%
20-49	29.7%	26.7%	30.8%
50-249	64.8%	40.8%	52.8%
250 plus	63.3%	77.4%	82.8%

Base: 1899 firms in 2020, 1551 in 2021, 1904 in 2022

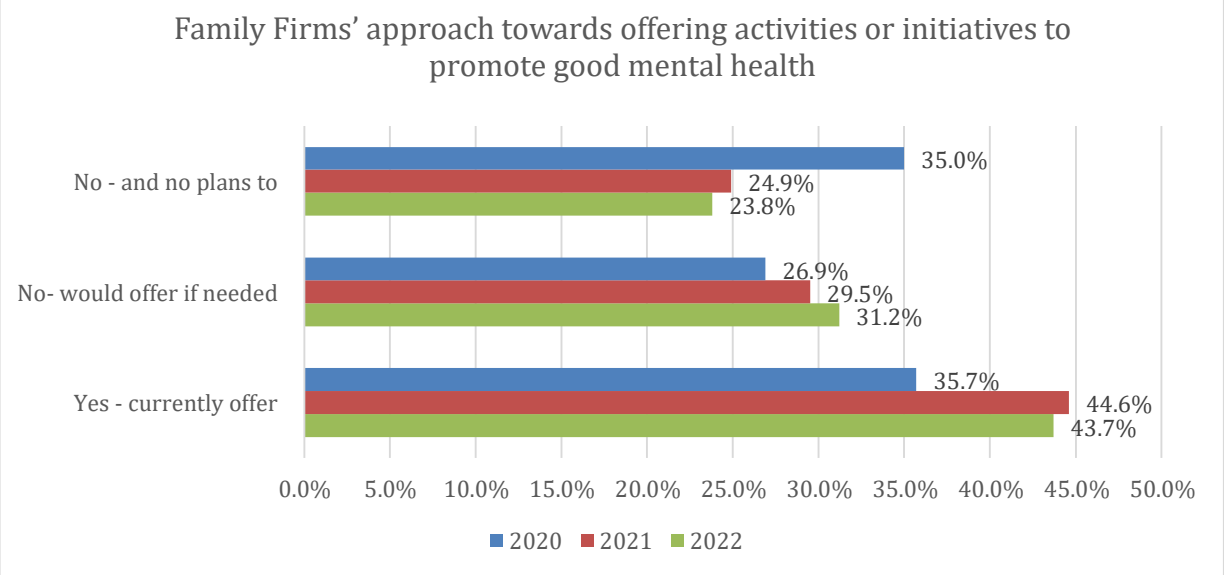
The proportion of nonfamily firms reporting mental health-related sickness absence has decreased since the pandemic in all sectors, except interestingly, the hospitality sector and other services which increased. For instance, the proportion of nonfamily firms reporting mental health-related sickness absence in the hospitality sectors increased above post pandemic levels (from 32 percent to 38 percent), we observe that the opposite occurred for family firms. The proportion of family firms reporting mental health-related sickness absence in the hospitality sectors decreased since the pandemic (from 22 percent to 19 percent).

Ultimately, mental health can have an impact on business in several ways including absenteeism, presenteeism and staff turnover. Therefore, in the next subsection, we consider the role that employers play in dealing with mental health issues at the workplace.

4.2 Mental health well-being & practices

In this subsection, we explore various mental health practices firms adopted since the pandemic. The eight practices we considered were having a mental health plan, having a mental health lead at the board level, using data to monitor employee wellbeing, providing support for those returning to work, having a mental health budget, providing awareness training for staff on mental health issues, providing training for line managers in managing mental health issues and using risk assessments or stress audits.

Figure 4.3: Family Firms' approach towards offering activities or initiatives to promote good mental health.

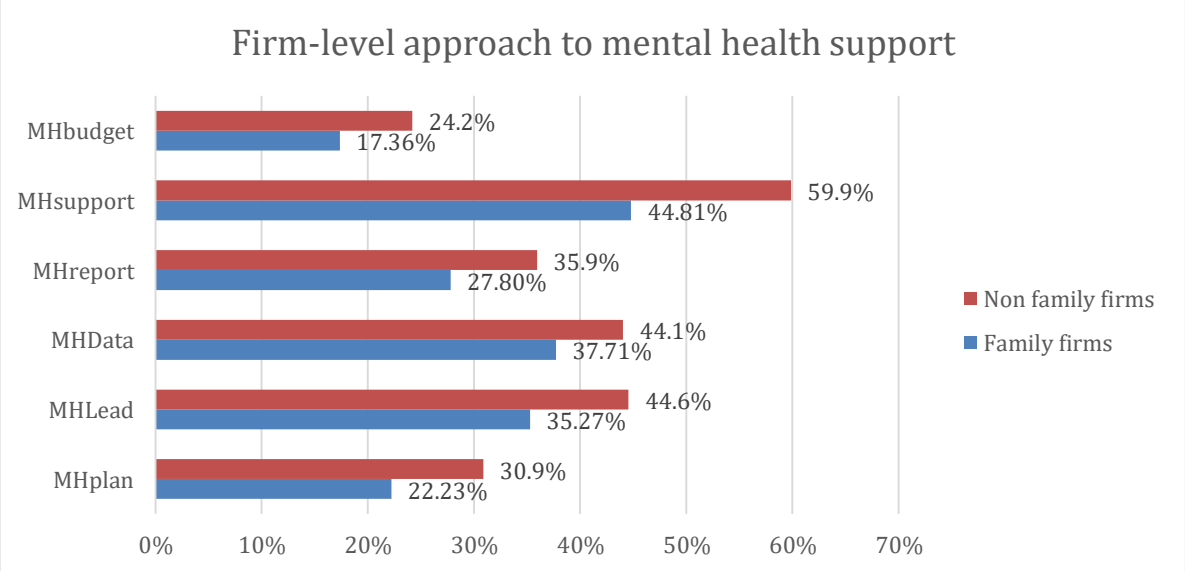


Base: 1037 family firms in 2020, 920 in 2021, 1102 in 2022

As per Figure 4.3, the proportion of firms currently offering mental health initiatives is stable since the pandemic at just over half, having increased from around 44 percent of firms' pre-pandemic. Firms are willing to offer more initiatives to promote good mental health if needed since the pandemic. A lower proportion of family firms (44 percent of firms) are currently offering support to promote good workplace mental health compared to nonfamily firms (56 percent of firms) post pandemic.

Although engagement with workplace initiatives to support mental health has increased, firms are more likely to have adopted approaches that did not require additional funding. The most widely adopted initiative by firms was the support of employees in-house, including suggesting available services, and the second most widely adopted was to monitor employee well-being (see Figure 4.4). Out of the six initiatives adopted to support mental health, the least adopted is firms allocating a budget for mental health and well-being activities (20.8 percent), followed by the mental health plan (26.5 percent). We observe that a higher proportion of nonfamily firms support mental health initiatives than compared to family firms (see Figure 4.4).

Figure 4.4: Firm-level approach to mental health support.



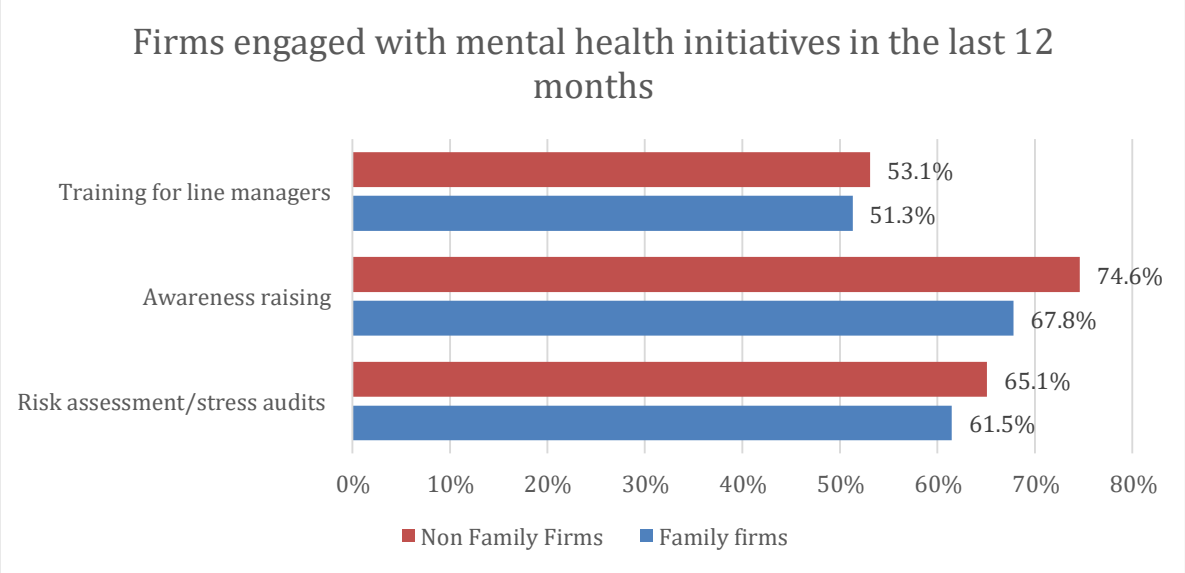
Base: 1899 firms in 2020, 1551 in 2021, 1904 in 2022.

We examine the skills training and monitoring activities embedded in firms that are designed to develop mental health management skills in line managers and other issues which may impact mental health and well-being. We consider three initiatives to support mental health in the workplace that has taken place in firms over the last 12 months:

awareness raising for staff on mental health issues, training for line managers and risk assessments/stress audits.

The proportion of firms' awareness raising for staff on mental health issues has increased since the pandemic. Over half of firms offered line manager training in managing mental health and over 60 percent of firms carrying out risk assessments/stress audits. The proportion of nonfamily firms implementing training and monitoring activities is higher than in family firms (see Figure 4.5).

Figure 4.5: Provision of workplace mental health support activities.

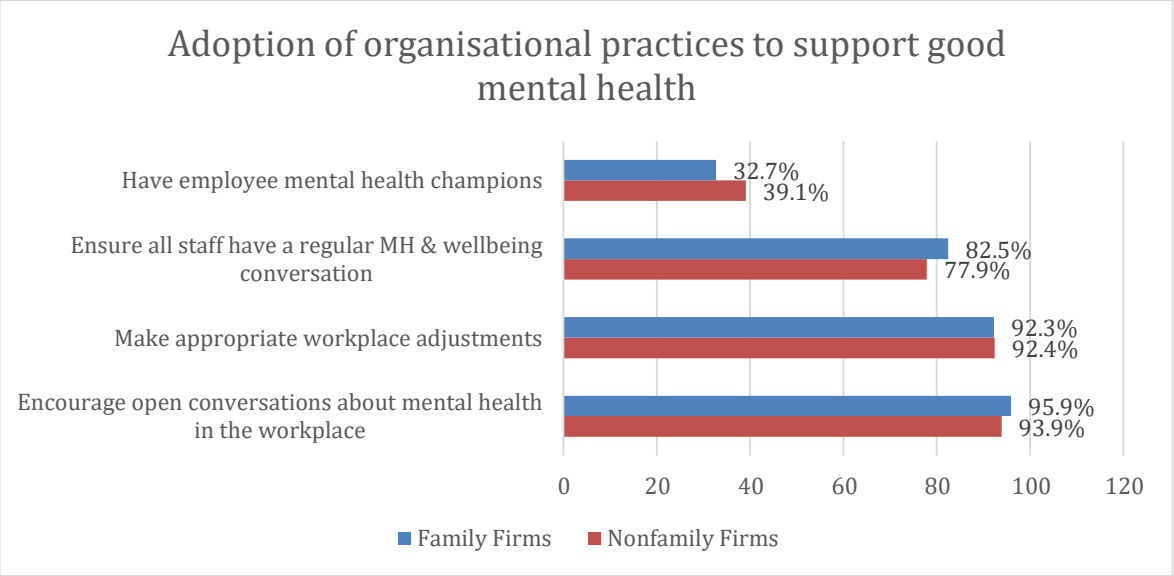


Base: 1904 firms in 2022.

4.3 Workplace practices to reduce work related risk factors

Furthermore, we consider the workplace practices designed to protect mental health by encouraging mental health self-care and reducing work -related risk factors. We observe high adoption of several firm-level practices aimed at supporting mental health in family firms, including encouraging open conversations (95.9 percent), making appropriate workplace adjustments (92.3 percent) and ensuring that all staff has regular well-being conversations (82.5 percent). The practices adopted are higher in family firms than in non-family firms except for employing mental health champions (see figure 4.6).

Figure 4.6: Adoption of organisational practices to support good mental health.



Base: 1899 firms in 2020, 1551 in 2021, 1904 in 2022.

In summary, the firms we surveyed recognise that they have a role to play in supporting their employees' mental health and well-being, and more than 50 per cent – are already offering initiatives and activities to help with this. The proportion of family firms (44 percent of firms) and nonfamily firms (56 percent of firms) currently offering initiatives and activities increased since 2020. More importantly, overall, we observe the proportion of firms that have adopted a range of practices related to mental health and well-being is growing.

5. NEXT STEPS

To develop this paper further, our study aims to extend the family firm literature as we consider the management practices adopted by family firms. Embedded in Resource Based View of the firm (Habbershon and Williams, 1999), our paper is concerned with examining how family firms' managerial practices support employees mental health and well-being. Given there is limited empirical evidence on which type of interventions are adopted in family firms (Arijs and Michiels, 2021), we plan to employ a quantitative regression analysis that explores the organizational performance of family-owned firms and the management practices adopted. Our theoretical contribution centres on organizational performance, and contributes to the lack of understanding in the specific context of mental health in family firms (Arijs and Michiels, 2021).

The effects of COVID-19 will drive further mental health issues in the workplace, as ongoing uncertainty gives rise to stress and anxiety and individuals continue to feel the aftereffects

of the major changes the pandemic has brought. This is something that employers, support agencies and policymakers will need to consider as they develop future plans. The findings from this paper will contribute to policy making as the support for organisational practices such as educational programs, and management training would increase awareness and support for mental health in the workplace.

ANNEX 1: VARIABLE DEFINITIONS

Variable Name	Definition
Absenteeism Mental Health Sickness Absence Long-term sickness	Categorical variables which take account of the total number of sickness days per employee. Binary variables which take value 1 if the firm has had staff taking repeated sickness absence in the last 12 months.
Presenteeism	Binary variable taking value 1 if the firm has had any instances of presenteeism in the business.
Staff Turnover	The amount of firm turnover is divided by firm employment.
Family owned	Binary variable taking value 1 where the business is family owned.
Family Managed	Binary variable taking value 1 where the business is managed by a family member.
Skills Training & Monitoring Activities	
Mental health audit	A binary variable taking value 1 where the business has undertaken risk assessment/stress audits at the site in the last 12 months.
Mental health awareness	A binary variable taking value 1 where the business has increased awareness for staff on mental issues at the site in the last 12 months.
Training	A binary variable taking value 1 where the business has line manager training to manage mental health at the site in the last 12 months.
Mental health variables	
Mental health prod	Binary variable taking value 1 where the business performance has been impacted by sickness absence due to mental health problems.
Mental health issues	A binary variable taking value 1 where the business has in the last 12 months had any staff off sick for any length of time due to mental health problems, including illness such as bipolar disorder, depression, anxiety, or stress and including any mental health issues brought about due to COVID-19.
Mental health initiatives	Binary variable taking value 1 where the business offers any activities or initiatives to promote good mental health at the workplace.
Workplace practices	
Open communication	Binary variable taking value 1 where the business has encouraged conversations about mental health in the workplace.
Support	Binary variable taking value 1 where the business has made workplace adjustments to who needs them to support their mental health.
Regular conversations	Binary variable taking value 1 where the business ensures all staff has regular conversations about their health and wellbeing with their managers.
Champion	Binary variable taking value 1 where the business has employee mental health champions.
Strategic Initiatives	
Mental Health plan	A binary variable taking value 1 where the business has a mental health plan.
Health lead	A binary variable taking value 1 where the business has a health and wellbeing lead at the board or senior level.
Budget	A binary variable taking value 1 where the business has a budget for mental health and wellbeing activities.
Data	A binary variable taking value 1 where the business uses data to monitor employee health and wellbeing.
Other Variables	
Firm age	Age of the business measured in years.
Firm size	Size of the business measured by employment: (20-49; 50-249;250+)
Firm sector	1 " Production" 2 "Construction" 3 "Wholesale, retail" 4 "Hospitality" 5 "Business Services" 6 "Other services"

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