RESEARCH PAPER · 45

Train the Manager, Move the Team

Manager mental-health training and employee outcomes: an updated meta-analysis

Dr Atul Aswani; Mumbai Psychiatrist and trained as a Results Coach
22 September 2026

KEY NUMBER

6

Six independent controlled programmes from 2010 to 2026 measured at least one employee-level outcome after manager mental-health training. A new pooled Hedges g was not calculated.

Train the Manager, Move the Team

Manager mental-health training and employee outcomes: an updated meta-analysis

Gayed 2018 found managers' knowledge changed; employees' outcomes were thin. Eight years later, does training the manager move the team?

SYSTEMATIC REVIEW · LIVING UPDATE OF GAYED 2018

PRISMA-2020 living update · years 2010–2026 · employee-level primary estimate

A new pooled Hedges g is not yet possible. Inherited WHO estimate: SMD −0.15.

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01

Abstract

Gayed and colleagues asked, in 2018, whether training workplace managers changed anything that employees could feel. Manager knowledge moved (SMD 0.73). Employee psychological symptoms did not: SMD −0.08 (95 per cent CI −0.21 to 0.06; p = 0.28; I^2 = 0 per cent). A new pooled Hedges g for employee outcomes is not yet possible: six independent controlled programmes from 2010 to 2026 measured different employee constructs, two were pilots, and comparable wellbeing or distress estimates number fewer than five. The last official pooled figure that includes later trials is the World Health Organization 2022 update of Gayed: standardised mean difference −0.15 (95 per cent CI −0.29 to −0.02) across six randomised trials, high certainty in the WHO text, most of them older than our year window. Our 2010–2026 living update finds one Australian cluster trial in which a four-hour face-to-face programme reduced work-related sick leave by 6.45 hours per employee over six months; one Canadian wait-list trial in which employees of trained managers used more workplace resources; and a consistent null or trivial signal on employee wellbeing scales in British and Australian trials. Employee-rated manager support leans positive when it is measured. Certainty of evidence for every employee-level domain is low by GRADE. No Indian randomised trial of workplace manager mental-health training with employee outcomes was found on CTRI or in the international databases. For an Indian workplace programme the honest reading is this: train the manager as a high-leverage practice, measure the team, and do not advertise a wellbeing effect the trials have not yet earned. The manager is the fine-tuning layer. The team is the held-out test set. Until Indian trials exist, the test set is still overseas.

02 Key findings box

KEY FINDINGS

6

Six independent controlled programmes from 2010 to 2026 measured at least one employee-level outcome after manager mental-health training. A new pooled Hedges g was not calculated.

–0.15

Employee wellbeing and distress remain small or null in the trials that used a wellbeing or distress scale. The inherited WHO pooled estimate is SMD –0.15 (95 per cent CI –0.29 to –0.02).

6.45

Work-related sickness absence fell by 6.45 hours per employee over six months in one large Australian emergency-service cluster trial (p = 0.049). Standard sick leave did not move. The finding has not been replicated.

82

Employee resource use rose after a three-hour Canadian awareness session (employees n = 82). That is one trial. GRADE certainty: low.

0

Zero Indian randomised trials of workplace manager mental-health training with employee outcomes were identified. Fewer than one in five Indian employees are thriving on Gallup’s life-evaluation measure.

03 Definition block

DEFINITION

Manager mental-health training is a short, structured practice that teaches people who supervise others how to notice distress, speak about it without stigma, adjust work where they can, and point a colleague toward help. It is not a diagnosis. It is not a clinical session. It is not therapy delivered by a line manager. Think of it as a set of countable reps: a check-in that is actually a check-in, a workload conversation that names the load, a sentence that says “this is common and here is where support lives.” The programme works on two things: how the manager reads a colleague who is struggling, and what the manager does next. When the urge is to let the silence at the next desk pass, the rep is to pull up a chair. And the person who sets the team’s context learns to stay steady, and flexible, when a deadline and a person collide. In machine-learning terms, you do not retrain every token in the model. You fine-tune the layer that conditions the rest. The manager is that layer.

04 Introduction

A joke travels well in Indian offices. The manager says, “My door is always open.” The team hears, “Do not walk through it unless the building is on fire.” So the exhausted analyst says “all good” at the Monday stand-up. That is the whole problem in one hallway.

Eight years ago Gayed and colleagues published a systematic review in Occupational and Environmental Medicine. They found ten controlled trials of workplace programmes that trained managers to understand and support the mental-health needs of the people who reported to them. Manager knowledge improved (standardised mean difference 0.73). Non-stigmatising attitudes improved (0.36). Self-reported supportive behaviour improved (0.59). Psychological symptoms in employees did not show a significant pooled effect (SMD −0.08; 95 per cent CI −0.21 to 0.06; p = 0.28; I^2 = 0 per cent). The authors said the employee finding was preliminary because almost nobody had measured the team.

That is the question this paper settles, or declines to settle: does training the manager move the team?

Picture two team leads in Bengaluru who sat the same workshop and scored well on the same quiz. On Monday the first one notices that a quiet engineer has been logging off late and logging back on after midnight all week. She walks over and asks, “How are you really doing?” The second means to ask and does not. Only the first is doing what the training was for. Manager training that changes a quiz score and leaves the roster untouched is knowledge without practice. Behaviour-change research has been saying a related thing for fifty years: an intention that never meets a behaviour is a hypothesis that was never run. The drill is plain. If the urge is to look away from a struggling colleague, look toward them, on purpose, for two minutes. When the sprint plan and the person collide, the question is what the manager actually values. Entrepreneurship asks a colder question: what is the unit of leverage? Training ten employees is a cost. Training one manager who sets the context for ten employees is a multiplier — if, and only if, the multiplier shows up in employee data.

India is not a footnote to this question. It is the reason EmotionApp exists. Gallup’s State of the Global Workplace series finds that fewer than one in five Indian employees are thriving on life evaluation. The rest are struggling or suffering. Daily anger in the 2024 cycle was 35 per cent, the highest rate in South Asia. A joint Confederation of Indian Industry and MediBuddy report in 2024 put work-related burnout among Indian employees at 62 per cent, against a cited global figure near 20 per cent. Deloitte’s 2022 India mental-health survey, reported by Reuters, estimated that poor employee mental health costs Indian firms about 14 billion US dollars a year through absenteeism, presenteeism and attrition. Four in five of the near-four-thousand employees surveyed said they had faced a mental-health issue in the previous year. Thirty-nine per cent said stigma stopped them acting. A 2024 industry report from a large Indian employee-assistance provider found that 59 per cent of employees referred by a manager showed signs of suicidal risk. That last number is not a trial result. It is a warning light on the dashboard: the manager is already the detection layer, trained or not.

The World Health Organization’s 2022 Guidelines on mental health at work made a strong recommendation, with moderate-certainty evidence, that training managers to support workers’ mental health should be delivered — to improve managers’ knowledge, attitudes and behaviours, and to improve workers’ help-seeking. NICE guideline NG212, issued the same year in the United Kingdom, told employers to offer systematic support and regular refresher training for managers, and then asked a research question the evidence still cannot answer: what is the long-term effect, beyond six months, of manager training on employee mental wellbeing?

This paper is a PRISMA-2020-informed living update of Gayed 2018, read against Milligan-Saville 2017, Stuber 2021, the WHO 2022 evidence profile, NICE NG212 review B, and the controlled trials published through September 2026. The population is managers and their direct reports. The intervention is mental-health or wellbeing training aimed at how managers support staff. The

comparator is any control. The primary outcomes are employee-level: wellbeing, help-seeking, sickness absence, and employee-rated manager behaviour. Years are 2010 to 2026. Designs are randomised and controlled trials.

A null result is publishable. A thin result is publishable. A result that is strong for the manager and quiet for the team is the result the field keeps returning. The task is to say that plainly, without dressing a coaching programme up as a clinic.

05 Methods

Eligibility

Population: managers, supervisors or team leaders and the employees who report to them.

Intervention or exposure: a workplace programme that trains those managers in mental health or wellbeing with the explicit aim of supporting staff. Generic leadership courses without mental-health content were excluded. Programmes that trained the whole workforce, including managers, as a single audience were excluded unless a manager-specific arm could be separated. Manager self-care programmes with no staff-support component were excluded. Family-supportive or sleep-supportive supervisor training without mental-health content was excluded.

Comparator: wait-list, usual practice, deferred training, or any other control.

Primary outcomes, employee-level only for the primary estimate: employee wellbeing or psychological distress; help-seeking or use of workplace resources; sickness absence or disability leave; employee-rated manager support or behaviour.

Secondary outcomes, reported for context and not pooled into the primary estimate: manager knowledge, attitudes, confidence and self-reported behaviour.

Study designs: randomised controlled trials and non-randomised controlled trials. Uncontrolled before-after studies, observational firm surveys and qualitative-only papers were excluded from the effectiveness synthesis.

Years: 1 January 2010 to 22 September 2026.

Setting and language: any country, any language of delivery, with English-language reports or English-language abstracts sufficient for extraction. Indian trial registries were searched specifically.

Information sources and search

This review is a living update of Gayed and colleagues (search to 14 August 2017) and of the WHO 2022 evidence profile that updated Gayed (search from 14 August 2017 to 4 March 2021), extended through September 2026. We searched PubMed, PsycINFO, Scopus, Web of Science, Google Scholar, the Clinical Trials Registry — India (CTRI), ClinicalTrials.gov and OSF preprints. Reference lists of Gayed 2018, Stuber 2021, Kuehnl 2019 (Cochrane), NICE NG212 evidence review B and the WHO 2022 web annex were hand-searched.

PubMed

(manager*[tiab] OR supervisor*[tiab] OR leader*[tiab]) AND ("mental health"[tiab] OR wellbeing[tiab] OR well-being[tiab] OR "mental wellbeing"[tiab]) AND (train*[tiab] OR program*[tiab] OR programme*[tiab] OR workshop*[tiab]) AND (randomi*[tiab] OR "controlled trial"[tiab] OR RCT[tiab]) AND (2010:2026[dp])

PsycINFO

(manager* OR supervisor* OR leader*) AND ("mental health" OR wellbeing OR well-being) AND (train* OR program* OR programme*) AND (randomi* OR "controlled trial")

Scopus

TITLE-ABS-KEY((manager* OR supervisor* OR leader*) AND ("mental health" OR wellbeing OR well-being) AND (train* OR program*) AND (randomi* OR "controlled trial")) AND PUBYEAR > 2009 AND PUBYEAR < 2027

Web of Science

TS=((manager* OR supervisor* OR leader*) AND ("mental health" OR wellbeing OR well-being) AND (train* OR program*) AND (randomi* OR "controlled trial")) AND PY=(2010-2026)

Google Scholar (first 20 pages, two strings): “manager” OR “supervisor” “mental health” training randomi* employee; and “line manager” wellbeing training randomised OR randomized workplace.

CTRI: manager AND mental health; supervisor AND training AND workplace; leader AND wellbeing AND trial.

ClinicalTrials.gov: Condition or disease: mental health. Other terms: manager training OR supervisor training. Study type: interventional. Dates: 01/01/2010 to 22/09/2026.

OSF preprints: manager mental health training.

Core terms specified by protocol: (manager OR supervisor OR leader) AND (“mental health” OR wellbeing) AND training AND randomi*.

Selection and extraction

Titles and abstracts from the increment search were screened against the eligibility criteria. Full texts were retrieved for any record that trained managers in mental health or wellbeing and mentioned employees, teams, direct reports, sickness absence, help-seeking or wellbeing. Extraction fields were pre-specified: study identifier; year; country; language of delivery; design; number of managers (intervention and control); number of employees (intervention and control); dose in sessions and minutes; delivery channel; guidance (facilitated or self-guided); outcome measure; timepoints; employee-level result; risk-of-bias judgement.

Only real, verifiable studies with a DOI or a stable registry or publisher URL were eligible. Anything that could not be verified was marked UNVERIFIED and excluded.

Analysis plan

The protocol specified a random-effects model using restricted maximum likelihood, Hedges g with a 95 per cent confidence interval, I^2, tau-squared, a 95 per cent prediction interval, Egger's test, trim-and-fill, leave-one-out sensitivity analysis, RoB 2 and GRADE.

The protocol also specified a fallback. If fewer than five eligible trials were found for the primary estimate, the review would deliver a systematic review with narrative synthesis, state plainly that a meta-analysis is not yet possible, and not pool.

Employee-level outcomes were the only outcomes eligible for the primary estimate. Manager knowledge, attitudes and behaviour were treated as mechanisms, not as substitutes for team outcomes.

Pre-specified moderators — training length, follow-up duration and whether the outcome was measured in employees — were examined narratively. Formal moderator tests were not run.

Risk of bias for randomised trials was judged with RoB 2, including the cluster-randomised variant where clusters were managers or organisations. Certainty of evidence was judged with GRADE by outcome domain, not by a single composite.

Position against prior evidence

Gayed 2018 remains the index review. Milligan-Saville 2017 is the flagship employee-absence trial inside that generation. Stuber 2021 reviews health-oriented leadership interventions in healthcare and is cited for sector context, not as a substitute pool. The WHO 2022 guidelines and their web annex are the last official pooled estimate for supervisee symptoms and help-seeking. NICE NG212 review B is the last national-guideline evidence review of manager interventions. Kuehnl 2019 (Cochrane) is cited as the broader human-resource-management supervisor-training review, which found no consistent effect on employee stress or absence when the training was not specific to mental health.

Honesty about the flow

This is a living update, not a claim that four reviewers dual-screened ten thousand raw records in September 2026. Gayed identified 1,332 unique records, screened 55 full texts and included ten controlled trials (nine papers). The WHO update searched MEDLINE, PsycINFO, EMBASE, Cochrane and PubMed from 14 August 2017 to 4 March 2021. Our increment search in September 2026 targeted the post-2017 window, applied the 2010 start-year filter, and required an employee-level outcome. Pre-2010 Japanese controlled trials that sat inside Gayed's employee-symptom forest plot were retained only as historical context. They were not treated as eligible for a new 2010–2026 pool.

Indicative PRISMA-style counts for the living update:

- Records already mapped by Gayed 2018: 1,332 unique.
- Full texts in Gayed: 55.
- Controlled trials in Gayed: 10 (nine papers).
- Additional unique trial reports identified in the WHO 2022 update and in the 2021–2026 increment: 14 full texts inspected in detail.
- Independent trial programmes with at least one employee-level outcome, 2010–2026, meeting eligibility: 6.
- Independent trial programmes entering narrative synthesis: 6.
- Studies entering a new quantitative pool: 0.

06 Results

Study characteristics

Six independent controlled programmes met eligibility for an employee-level narrative synthesis. One additional paper (Mohr and colleagues, 2024) reports a second employee outcome from the same United States Army trial as Hammer and colleagues (2024) and is not counted as a seventh trial.

Table 1. Study characteristics of eligible 2010–2026 controlled trials with employee-level outcomes

Study	Country	Design	Managers	Employees	Dose	Channel	Employee outcomes
Stansfeld 2015	UK	Pilot cRCT	41 from 3 int. sites; 1 ctrl site	225 / 59 follow-up	~2.5 h / 10 wks	Facilitated e-learning	Wellbeing, distress, HR absence
Milligan-Saville 2017	Australia	Cluster RCT	25 / 19 analysed (46 / 42 rand.)	1,233 / 733	One 4-hour session	Face-to-face, facilitated	Work-related and standard sick leave, 6 mo
Dimoff & Kelloway 2019	Canada	Wait-list RCT	37 leaders	82 employees	One 3-hour session	Face-to-face, facilitated	Employee-rated support; resource use, 3 mo
Gayed 2019	Australia	Cluster RCT	87 / 123	167 / 224 baseline; 70 / 103 at 4 mo	Self-paced modules	Online, self-guided	Employee psychological distress, 4 mo
Hammer 2024 / Mohr 2024 (same trial)	USA	Cluster RCT	99 leaders	276 soldiers; loneliness 118 vs 158	~90 minutes	Hybrid, facilitated	Anger, loneliness, perceived support, 3 mo
Hassard 2025	UK	Pilot cRCT	141 / 83; 24 organisations	74 / 38 direct reports	Five web modules	Online, self-guided	Wellbeing and perceived competency, 3 mo

Dose ranged from 90 minutes to four hours for the single-session programmes, and from a handful of short modules to ten weeks for the online programmes. Follow-up clustered at three to six months. No eligible trial followed employee outcomes past nine months as a pre-specified primary endpoint. Language of delivery in every eligible trial was English. Countries were Australia, Canada, the United Kingdom and the United States. None was India.

What each trial found for employees

Stansfeld and colleagues ran a pilot cluster trial of guided e-learning for managers in four National Health Service mental-health services. Employee wellbeing scores fell slightly in both arms. The adjusted intervention effect was 0.5 points on a 14-item wellbeing scale (95 per cent CI −3.2 to 4.2). That interval includes a harm, a nothing, and a small help. Human-resources sickness-absence data showed no benefit. A post-hoc split found that employees whose managers actually completed at least three modules lost less wellbeing than employees whose managers did not (adjusted difference 1.6 points, 95 per cent CI 0.1 to 3.2). The lesson is not “e-learning works.” The lesson is “uncompleted modules do not.”

Milligan-Saville and colleagues cluster-randomised duty commanders in a large Australian fire and rescue service to a four-hour face-to-face programme or deferred training. During six months of follow-up, work-related sick leave fell by 0.28 percentage points from 1.56 per cent in the intervention group and rose by 0.28 percentage points from 0.95 per cent in the control group ($p = 0.049$). That difference corresponds to 6.45 hours per employee over six months. Standard sick leave did not differ ($p = 0.169$). The authors estimated a return of £9.98 for each pound spent. Manager knowledge and confidence improved. The p-value sits on the edge of conventional significance. The outcome is administrative, which is a strength. The setting is an emergency service, which is a limit.

Dimoff and Kelloway assigned leaders at random to a three-hour mental-health awareness session or a wait-list. Employees of trained leaders reported that those leaders shared more information, were more supportive and more often encouraged use of available resources. The employees themselves reported greater willingness to seek those resources. Follow-up stopped at three months. The employee sample was 82 people. The WHO 2022 annex treats a help-seeking effect from this line of work as SMD 1.416 (0.88 to 1.95), low certainty, one study — that extraction is WHO's, not a figure we recomputed from raw cells.

Gayed and colleagues cluster-randomised Australian managers to a self-paced online programme or a wait-list. Manager confidence and both responsive and preventive behaviours improved, more clearly among completers. Psychological distress among 173 employees who answered at four months did not differ between arms ($F(1, 184.65) = 0.57$, $p = 0.57$). The manager moved. The team's distress score did not.

Hammer and colleagues cluster-randomised United States Army platoon leaders to a 90-minute hybrid programme or control. Soldiers whose leaders were trained reported less problematic anger three months later ($d = 0.27$, $p = 0.002$). Mohr and colleagues, on the same trial, reported lower loneliness in the intervention soldiers ($d = −0.21$) and a stronger support signal among those who had been lonelier at baseline. This is a real employee-level effect. It is also a military sample, a short follow-up and a construct (anger, loneliness) that is adjacent to, not identical with, a generic wellbeing scale.

Hassard, Blake and colleagues piloted a self-guided web programme across 24 United Kingdom organisations. Manager confidence, knowledge, literacy and wellbeing improved with moderate-to-large within-trial contrasts (manager confidence $d = 1.0$). Direct reports numbered 112. Their wellbeing and their ratings of manager competency moved in a helpful direction and did not reach statistical significance. The paper is a feasibility trial. It should not be read as a failed effectiveness trial or as a successful one.

Forest-plot data table

A forest plot of a single employee outcome is not presented. The protocol forbade pooling when comparable trials numbered fewer than five. Table 2 records the extractable employee-level estimates so a later update can pool them when the field earns it.

Table 2. Extractable employee-level estimates (not pooled)

Study	Construct	Estimate	CI or p	n employees
Stansfeld 2015	Wellbeing scale, points	+0.5	−3.2 to 4.2	284
Stansfeld 2015	Approx. Hedges g	~0.06	~ −0.23 to 0.35	284
Gayed 2019	Psychological distress	Null	p = 0.57	173
Hammer 2024	Problematic anger (lower better)	d = 0.27	p = 0.002	276
Mohr 2024 (same trial)	Loneliness	d = −0.21	p < 0.05	118 vs 158
Hassard 2025	Wellbeing / perceived competency	NS improvement	Not significant	112
Milligan-Saville 2017	Work-related sick leave	−0.28 vs +0.28 pp	p = 0.049	1,966
Stansfeld 2015	Sickness absence	No benefit	—	393
Dimoff & Kelloway 2019	Resource use / willingness	Increase vs wait-list	Sig. at 3 months	82
Gayed 2018 (context)	Employee symptoms	SMD −0.08	−0.21 to 0.06; p = 0.28; I^2 = 0%	Mostly pre-2010
WHO 2022 update (context)	Supervisee MH symptoms	SMD −0.15	−0.29 to −0.02	596 vs 350

Moderator table

Table 3. Pre-specified moderators, narrative

Moderator	Pattern across the six programmes	Implication
Training length	90 minutes (Hammer) to 4 hours face-to-face (Milligan-Saville) to multi-week online (Stansfeld, Gayed, Hassard)	The only clear absence signal sits in the four-hour facilitated session. Online programmes moved manager scores more reliably than employee scores.
Follow-up	3–6 months in every eligible trial	NICE NG212 already flagged follow-up beyond 6 months as a research gap. It remains a gap.
Employee-level measurement	Still the exception. Most recent manager-training trials still power on manager confidence.	A programme can look effective on the person in the room and be silent on the people who were not invited.

Formal tests of these moderators were not run. Six programmes and four constructs do not support a meta-regression that anyone should quote.

Heterogeneity

Statistical heterogeneity for a new pool was not computed, because a new pool was not computed. Clinical heterogeneity is obvious and is the reason the fallback was triggered. Emergency-service firefighters in New South Wales are not NHS mental-health staff in London, who are not Canadian corporate employees, who are not United States soldiers, who are not mixed-sector United Kingdom office workers. A four-hour facilitated conversation is not five self-guided web modules. Work-related sick leave is not a six-item distress scale. Anger is not flourishing.

Gayed's original employee-symptom analysis reported SMD −0.08 (95 per cent CI −0.21 to 0.06; p = 0.28; I^2 = 0 per cent). A follow-up of three months or more in that review was SMD 0.08 (95 per cent CI −0.23 to 0.38; p = 0.62). The WHO 2022 annex, adding later trials and keeping some of the older Japanese work, reported SMD −0.15 (95 per cent CI −0.29 to −0.02) with high certainty for supervisee symptoms at three to four months. That interval just excludes zero. The point estimate is small. Our year window and our employee-construct filter do not reproduce a five-trial set that would let us replace that number.

Publication bias

Egger's test and trim-and-fill were not run on a pool that does not exist. Small-study effects remain a live risk. The employee-level literature is still a handful of trials, several of them pilots, several of them from the same Australian research group that produced Gayed and Milligan-Saville. Negative or null employee findings have been published (Stansfeld, Gayed 2019, Hassard), which is to the field's credit. That does not rule out a file drawer of unregistered manager-training evaluations inside firms.

Risk-of-bias summary

Table 4. RoB 2 judgements for employee-level estimates

Trial	Randomisation	Deviations	Missing data	Outcome measurement	Selection of result	Overall
Stansfeld 2015	Some concerns	Some concerns	Some concerns	Some concerns	Some concerns	Some concerns
Milligan-Saville 2017	Low / some	Some concerns	Low for admin. leave	Low for admin. leave	Some concerns	Some concerns
Dimoff & Kelloway 2019	Some concerns	Some concerns	High / some	Some concerns	Some concerns	Some concerns
Gayed 2019	Some concerns	Some concerns	High	Some concerns	Some concerns	High (employee est.)
Hammer / Mohr 2024	Some concerns	Some concerns	Some concerns	Some concerns	Low / some	Some concerns
Hassard 2025	Some concerns	Some concerns	High at 6 months	Some concerns	High (feasibility)	High (effectiveness)

No eligible trial was at low risk of bias across all domains for an employee-level estimate. Administrative sickness absence in Milligan-Saville is the cleanest outcome measurement in the set.

GRADE table

Table 5. GRADE by employee-level domain

Domain	Studies	Effect	Certainty	Direction
Wellbeing / distress	Stansfeld 2015; Gayed 2019; Hassard 2025; Hammer 2024 (anger proxy)	Small or null on generic scales; d = 0.27 anger in one military trial	Low	No consistent benefit on generic wellbeing
Help-seeking / resource use	Dimoff & Kelloway 2019 (WHO annex SMD 1.42)	Large in one small trial	Low	Benefit in one trial
Sickness absence	Milligan-Saville 2017; Stansfeld 2015	Work-related leave down in one trial; standard leave and NHS absence not improved	Low	Possible reduction in work-related leave; not replicated
Employee-rated manager behaviour	Dimoff 2019; Mohr 2024; Hassard 2025	Mixed; leans positive when measured	Low	Promising, thin

Inherited context, not re-graded here: WHO 2022 rated supervisee mental-health symptoms as high-certainty for a very small effect (SMD –0.15) after updating Gayed, and rated supervisee help-seeking as low-certainty from one trial. Those grades include evidence outside our year window. GRADE domains were downgraded for risk of bias, inconsistency of construct, indirectness (NHS, military, pilots) and imprecision.

07 Discussion

PULL QUOTE

Zero Indian randomised trials of workplace manager mental-health training with employee outcomes were found.

What the number means

The number that still governs the employee-symptom claim is small. WHO's update of Gayed put it at −0.15 standard deviations of psychological symptoms in supervisees, with a confidence interval that just clears zero. Gayed's own 2018 pool did not clear zero (SMD −0.08; 95 per cent CI −0.21 to 0.06). Our 2010–2026 window cannot replace either figure with a new Hedges g, because the trials that measured employees did not measure the same thing often enough.

That is not a failure of the question. It is a description of the evidence. Manager training reliably changes the person in the workshop. Knowledge goes up. Attitudes soften. Confidence rises. Self-reported behaviour improves. Gayed quantified those effects and later trials have not overturned them. Hassard's 2025 feasibility trial produced a Cohen's d near 1.0 for manager confidence. Hammer's leaders learned the material at d = 1.56. Gayed 2019 moved manager behaviour even when employee distress stayed flat.

The theoretical story writes itself and should be treated with suspicion for that reason. The manager is the context. Context shapes behaviour. Behaviour of the manager should shape the day of the employee. After training, a manager in Hyderabad who used to scroll past a quiet colleague's name on the roster books a slot and asks. The old fear, "if I ask, I will open a door I cannot close", gets tested in that room, and it often turns out to be wrong. Walking towards the hard conversation instead of away from it is the whole curriculum. In a machine-learning frame, you fine-tune the conditioning layer and expect the downstream tokens to shift. Sometimes they do. Anger in a platoon falls by a quarter of a standard deviation. Work-related leave in a fire service ticks down. Resource use in a Canadian firm ticks up. Sometimes they do not. A distress scale in Australian firms does not move. A wellbeing scale in the NHS does not move. A feasibility sample of United Kingdom direct reports does not move enough to count.

Entrepreneurs like multipliers. The multiplier here is real as a design and unproven as a wellbeing effect. Training one manager is cheaper than coaching an entire team. That is unit economics, not evidence. The evidence says:

budget for the training, budget for the measurement of the team, and do not print the multiplier on the sales slide until an Indian trial, or any fifth comparable wellbeing trial, exists.

Limitations

This review is a living update, not a de-novo dual-reviewer screen of every database hit since 2010. Counts in the flow statement are indicative and anchored to Gayed's published numbers plus an increment search. We may have missed unpublished industry evaluations and non-English full texts.

The eligible set is small, English-speaking and geographically narrow. Two programmes are pilots. One is military. One is an emergency service. Employee follow-up is often poor. Wait-lists do not control for attention. Almost nobody is blinded. Almost nobody follows employees past six months. Outcome constructs do not align. Administrative absence, the cleanest endpoint in the set, comes from a single trial with a p-value of 0.049.

We did not pool. Readers who want a single g will be tempted to compute one from Table 2. We ask them not to. Mixing a 0.5-point wellbeing change, a null distress test, an anger d of 0.27 and a non-significant feasibility contrast is how a field talks itself into a precision it did not earn.

India is absent from the trial set. That is a limitation of the literature, not only of this review.

WHAT THIS MEANS

What this means for an Indian workplace programme

Picture an HR head at a Pune manufacturer signing off a manager programme. She is not making a scientifically reckless choice. WHO already made a strong recommendation. NICE already told employers to train managers and to refresh the training. The manager-side effects are large enough, and consistent enough, to justify the time. What she should not do is show the board a slide promising that team wellbeing scores will rise in twelve weeks. They have not, reliably, in the countries that have run the trials.

Build the programme as countable reps, not as a one-off seminar. A four-hour facilitated session is the dose that moved work-related leave. Online modules that nobody finishes will reproduce Stansfeld's adherent-versus-non-adherent split: the link sits unopened while quarter-end eats the week. Measure the team: a short wellbeing item, a help-seeking item, and, where the human-resources system allows it, spells of absence. Run the conversation in the language the team actually speaks. EmotionApp already works in 23 Indian languages for a reason. Keep the data in India. Keep the manager on the right side of the line between coaching and clinic. The manager's job is to notice, to adjust work, and to hand off: "You have been online past midnight all week. I am moving the vendor deck to Friday. Here is who you can talk

to.” The hand-off is the ethical core. Hierarchical Indian offices punish disclosure. A trained manager lowers that cost. That is the theory. The Indian trial that tests it has not been registered.

Train the manager because the team is already at work. Then measure the team.

Research gaps, naming the India gap explicitly

The India gap is complete. CTRI searches for manager or supervisor mental-health training in workplaces returned no eligible randomised trial with employee outcomes. Community and primary-care training trials exist in India. They train champions, doctors and health workers, not workplace managers and their direct reports. That is a different population and a different intervention.

Beyond India the gaps are the ones NICE already named. Follow-up beyond six months. Employee-level primary endpoints. Sickness absence replicated outside one emergency service. Help-seeking replicated outside one Canadian firm. Moderators that a meta-regression could actually test: dose, facilitation, language, hierarchy, hybrid work. Trials in languages other than English. Trials that treat the manager programme as one layer in a stack — organisational design plus manager reps plus individual practices — rather than as a standalone product.

A fifth comparable wellbeing trial would make a pool defensible. An Indian cluster trial with employee wellbeing, help-seeking and absence as pre-specified endpoints would change the conversation this paper is in. Until then the honest product claim is the manager claim: knowledge, attitudes, confidence, behaviour. The team claim is still a hypothesis with a small inherited effect size and a wide prediction interval we cannot even compute.

08 FAQ

Q1 Does training managers improve employee wellbeing?

Not reliably on the scales used so far. Four 2010–2026 trials measured wellbeing or distress. Two were null. One was a non-significant feasibility contrast. One reduced anger by d = 0.27 in soldiers. The inherited WHO pool is SMD −0.15.

Q2 Will it cut sick leave?

One Australian cluster trial found 6.45 fewer hours of work-related sick leave per employee over six months (p = 0.049). Standard sick leave did not change. A British pilot found no absence benefit. Treat the 6.45 hours as a single-trial signal.

Q3 How long does the training need to be?

Successful manager-side studies run from 90 minutes to four hours. The absence signal sits at four facilitated hours. Online programmes work for managers who finish them. Unfinished modules do not.

Q4 Should Indian companies bother?

Yes, as a manager practice with a WHO strong recommendation. No, as a promised team-wellbeing product. Zero Indian employee-level trials exist. Measure your own team if you run the programme.

Q5 Is this therapy?

No. It is a workplace practice: notice, speak, adjust work, hand off. Line managers do not diagnose. They run reps and they pass the person to someone whose job is care.

09

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NOTE

EmotionApp is a non-clinical emotional-fitness coaching platform. This paper describes practices, techniques and coaching. It is not therapy, treatment, diagnosis or medical advice.

SAFETY NOTE

If you are in distress, please contact a qualified professional or Tele-MANAS on 14416.