SAMPLE DELIVERABLE · CLN-06

Workplace Mental-Health Program

A program design people actually use: prevention built into how work runs, support that is safe to reach, and response pathways rehearsed before they are needed.

Prepared for Northgate Services (fictional) by Red Cell Consulting

CONTENTS

About this document

This is a sample of the deliverable Red Cell Consulting produces in a real engagement. Every organisation, figure and finding in it is fictional, and the structure, depth and standards are exactly what a client receives. Where a real engagement would cite source documents, the sample says so.

Executive summary

Northgate employs around two hundred people across operations and office functions. This program is sized for that reality, owned by named roles, and measured on behaviour rather than sentiment.

The problem this solves

Most workplace mental-health programs are all support and no prevention, or all policy and no pathway: an EAP poster, an annual webinar, and silence between incidents. Usage stays low, strain stays where the work design put it, and the first time anyone tests the response pathway is during a crisis.

The design in one paragraph

Three pathways: prevent strain where work is designed, support people early and confidentially, respond well when something happens. Each pathway has an owner, a budget, a calendar and measures. Clinical services sit behind proper consent, and leadership sees themes, never individuals.

WHAT CHANGES FOR PEOPLE

- Managers know what to watch for, what they may ask, and where to route concern, because they have been trained on exactly that.
- Support is reachable in two clicks or one conversation, and using it is invisible to the org chart.
- Workload and rostering, the largest drivers of strain, are reviewed as design questions, not endurance tests.
- When something serious happens, the response is a rehearsed pathway, not an improvisation.

WHAT THIS PROGRAM IS NOT

It is not a substitute for clinical care, and it does not put managers in a clinical role. Where assessment or treatment is indicated, the program routes to registered practitioners with informed consent, and the workplace receives only what the person agrees to share.

Design principles and evidence

The program stands on what the evidence supports: work design first, early access second, and response readiness throughout.

PRINCIPLES

PRINCIPLE	WHAT IT MEANS HERE
Prevention beats treatment at population scale	The biggest levers are workload design, role clarity and manager behaviour, so the program spends most of its effort there
Access must be safe to be used	Support that is visible to management does not get used; confidentiality is engineered, not promised
Managers are the environment	People experience the organisation through their manager; capability there moves more than any campaign
Measure behaviour, not posters	Participation, time-to-access and return-to-work outcomes are measures; awareness is not
WHS duties are the floor, not the ceiling	Psychosocial hazard management is a legal duty; this program operationalises it rather than gesturing at it

THE PSYCHOSOCIAL HAZARD LENS

The prevention pathway is organised around the recognised hazard families: job demands, low control, poor support, role ambiguity, conflict exposure, and organisational change handled badly. Northgate's baseline (page six of the full engagement) concentrates in demands and change; the calendar reflects that weighting.

Honesty about limits

A workplace program shifts the conditions the workplace controls. It does not resolve clinical conditions, and pretending otherwise harms people. The line between program and clinic is drawn deliberately and marked with consent at every crossing.

The three pathways

Prevent, support, respond. Each with an owner, a budget line and a measure, because pathways without owners are posters.

PREVENT · OWNER: EXECUTIVE SPONSOR WITH PEOPLE LEAD

- Psychosocial hazard register established and reviewed quarterly against incidents and pulse data.
- Workload and rostering review in the two highest-strain functions, run as a design exercise with the teams.
- Manager training in early recognition and safe conversations (page five).
- Change protocol: any restructure or major process change carries a strain assessment before announcement.

SUPPORT · OWNER: PEOPLE LEAD

- Confidential access to the practitioner panel or EAP, reachable directly without manager involvement.
- An adjustment menu managers can offer without escalation: temporary load changes, schedule flexibility, duty variations.
- Named and trained peer-contact points, chosen by the teams, refreshed annually.

RESPOND · OWNER: PEOPLE LEAD WITH PRACTITIONER

- Incident and crisis steps on one page: who calls whom, in what order, with after-hours numbers that answer.
- Return-to-work pathway with graduated plans, agreed adjustments and review points at 30, 60 and 90 days.
- Referral route to clinical assessment where indicated, consent-based, with boundaries agreed in writing first.

How the pathways connect

Pulse and hazard data from Prevent tune where Support is promoted; patterns in Support usage (themes only) feed the hazard register; every Response case ends with a review of what Prevent could have caught. The program is a loop, not three silos.

Roles and confidentiality architecture

Who does what, who sees what, and the walls that make the program safe to use.

ROLES

ROLE	HOLDS	DOES NOT HOLD
Executive sponsor	Program budget, quarterly review, removal of blockers	Any individual usage information
People lead	Pathway operations, provider relationship, de-identified reporting	Clinical information beyond agreed disclosures
Managers	Early recognition, safe conversations, the adjustment menu	Diagnostic questions, treatment involvement, access records
Peer contacts	Listening, signposting	Case responsibility of any kind
Practitioners	Clinical work under their own governance	Reporting to the employer beyond consented summaries

THE CONFIDENTIALITY WALLS

- Support usage is reported only as participation counts and theme categories, at a minimum group size of ten.
- Referral to assessment happens only with informed consent, documented before the first appointment, including exactly what the employer will and will not receive.
- Managers are trained on the questions they may ask (about work, capacity and support) and the ones they may not (diagnosis, treatment, history).
- Records live with the provider, not in HR files; the employer holds only what the person agreed to share.

Why the walls are the program

Every wall above exists because its absence has a documented cost: support that management can see goes unused, and unused support is a budget line pretending to be care. Confidentiality is not compliance decoration; it is the mechanism that makes the rest work.

Manager capability build

Four modules, two hours each, run with real scenarios from this workplace. Capability, not awareness.

MODULE	CONTENT	PRACTICE COMPONENT
1 · Recognising early	What strain looks like at work: pattern changes, withdrawal, uncharacteristic errors; the difference between observing and diagnosing	Case walk-throughs from anonymised Northgate patterns
2 · The safe conversation	Opening without cornering; what to ask, what not to; listening without fixing; routing to support	Practised conversations with coached feedback
3 · Adjustments that work	The adjustment menu; setting and reviewing temporary changes; documenting without medicalising	Writing two adjustment plans against scenarios
4 · When it is serious	The response pathway step by step; after-hours reality; the manager's role during and after an incident	Tabletop run of the crisis pathway

REINFORCEMENT

- One-page aides for each module live where managers work, not in a portal nobody opens.
- Refresher scenario each quarter in the existing leadership meeting: fifteen minutes, one case, no slides.
- New managers complete the modules within ninety days of appointment; completion is tracked and visible.

The standard

The training goal is behavioural: every manager can recognise a pattern, hold one safe conversation, offer an adjustment, and route to the pathway without hesitation. Anything beyond that is the practitioners' job, and the training says so explicitly.

Twelve-month calendar and measures

What happens when, and how the program proves it is working.

CALENDAR

QUARTER	PREVENT	SUPPORT	RESPOND
Q1	Hazard register baseline; manager modules 1-2	Access relaunch; peer contacts selected	Pathway drafted; leadership tabletop
Q2	Workload review in two pilot functions; modules 3-4	Peer contacts trained; adjustment menu live	Return-to-work templates in use
Q3	Pulse round two; change protocol first use	Menu reviewed against uptake	Full tabletop exercise, realistic scenario
Q4	Register review against year's data	Provider review	Annual pathway review and sign-off

MEASURES

MEASURE	CADENCE	READ AS	YEAR-ONE TARGET
Driver pulse (demands, control, support)	Quarterly	Leading indicator of strain	Improvement in the two pilot functions
Support participation and time-to-access	Quarterly, de-identified	Whether help is reachable	Access under five business days
Adjustments offered and completed	Half-yearly	Whether managers use their tools	Every function has used the menu
Return-to-work outcomes at 90 days	Per case, aggregated	Whether the pathway holds	Plans completed as agreed
Manager module completion	Quarterly	Capability coverage	100 percent incl. new managers

Governance

Quarterly program review with the executive sponsor: measures, themes, hazard register movements, and one decision the data is asking for. Annual review resets the calendar. The program earns its budget the same way anything else does: by showing its work.

About Red Cell Consulting

Consulting and advisory, backed by platforms we design, build and operate ourselves.

Red Cell Consulting is a multi-disciplinary consultancy working across enterprise and technology, financial analysis, clinical psychology and behavioural science, advisory and investment readiness, restructuring, management consulting and AI governance. The distinctive part is that we also build: our platforms, including Recursys for deal intelligence, Myra for deterministic financial analysis and ADMRL for structured clinical reporting, run in production under the same disciplines we recommend to clients. When we advise on evidence, testing and governance, we are describing how our own systems work.

HOW AN ENGAGEMENT RUNS

STEP	WHAT HAPPENS
1 · Conversation	A free first discussion of the situation. We will tell you plainly whether we can help and what it would involve.
2 · Scope	A short written scope: the question, the deliverables, the timeline, the fee. Fixed where the work allows it.
3 · The work	Delivered in the structure this sample shows, with working sessions rather than big reveals. You see findings as they form.
4 · Handover	Deliverables that stand on their own, and the option of standing support where it makes sense.

FOR THIS SERVICE

Our clinical practice designs and runs programs like this one, and provides the assessment services behind them, delivered by registered practitioners under proper consent. If your current program is a poster and a phone number, start with the conversation.

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