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How schools and workplaces use evidence to navigate health and wellbeing investment decisions – a scoping review

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Abstract

Purpose – Despite increased calls for greater health and wellbeing promotion in workplaces and schools, little is known about how these organisations make use of evidence to support health and wellbeing investment decisions.

Design/methodology/approach – A scoping review was conducted to explore how workplaces and schools use evidence in their health and wellbeing investments decisions and to synthesise findings across a range of OECD countries.

Findings – A total of 27 studies from nine countries met inclusion criteria. Included studies were analysed thematically. Both studies of schools and workplaces faced challenges in identifying and using a variety of forms of evidence, due to insufficient time and human resources. We generated three themes based on the data extracted to explain how schools and workplaces used evidence to invest in health and wellbeing. These were '*Evidence-based provision adapted to context*' which looks at how evidence is used or not used in tandem with context of the decision; '*Having expertise'*, which reports decision-makers seeking expertise in their selection of evidence or reliance on their experiences to make a decision related to health and wellbeing; and '*Challenging the status quo'* which shows instances where evidence could be used to challenge decision-making and current wellbeing practice or prioritise different wellbeing areas. These findings highlight how organisational politics shapes which health and wellbeing evidence decision-makers choose to use-or ignore.

Originality/value – This review highlights how and why schools and workplaces choose to invest in health and wellbeing initiatives and how evidence use affects their selection. It shows how resources and power dynamics shape evidence use in decision-making processes about wellbeing and goes beyond seeing evidence as solely helping organisations to solve a specific problem.

Keywords Health and wellbeing, Evidence use, Schools, Workplaces, Decision-making, Resource allocation, Power

Paper type Research article

1. Background

A significant amount of an individual's lifetime can be spent in schools and at work, making these places essential for health and wellbeing promotion. However, little is known about how such organisations make use of evidence to support their health and wellbeing investment decisions. Cultures of evidence use vary through sectors and contexts (Lorenc *et al.*, 2014), and further research is needed on how and why particular types of evidence and knowledge become influential in specific organisational contexts (Turner *et al.*, 2022), particularly in an area as crucial as health and wellbeing promotion.

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There have been increased global pushes to promote health and wellbeing in workplaces and schools. For instance, new guidelines published by the World Health Organization (WHO) recommend actions to tackle risks to mental health, such as stressful work environments and heavy workloads (WHO, 2022). Similarly, UNESCO now actively encourages schools to implement a ‘whole-school approach’ to promote the mental wellbeing of children and young people (WHO and UNESCO, 2019). While education research constitutes a clear area of focus for school decision-makers (Coburn and Penuel, 2016), evidence related to health and wellbeing may fall outside their domain of expertise, creating an added decision-making pressure in these specific areas. In workplaces, there have been a growing number of wellbeing programmes being implemented by employers in recent years, after the Covid-19 pandemic, to support the mental and physical health of their employees (OECD, 2022). However, while wellbeing initiatives are often showcased as a source of pride for progressive human resource departments (Barry, 2024), there is limited information available about how such programmes are selected. This is especially true regarding the role of evidence use and its influence in organisational decision-making processes, which may affect the overall effectiveness of wellbeing initiatives (Daniels *et al*., 2021).

In this review, we make a distinction between evidence which is produced by external research bodies, and decisions based on internal evidence generated in the organisations. Evidence can be defined as “information that enables actors to judge whether a proposition is true or not” (Buse *et al*., 2024, p. 177). In organisational contexts, evidence-based management (or EBM) has been defined as the “systematic collection and judicious use of the best available evidence from multiple sources when making organizational decisions” (Criado-Perez *et al.*, 2024: 1,653). However, what is considered ‘evidence’ relates to what counts as ‘knowledge’, which varies, depending on epistemological, political and moral perspectives (Learmonth and Harding, 2006).

Given the important role played by schools and workplaces for health and wellbeing promotion, and the ambiguous role that evidence can play in affecting their decision-making processes, this scoping review aims to respond to the following research question: how are different forms of evidence currently used (or not) in schools and workplaces to select health and wellbeing initiatives? Studies focused on the use of evidence and the application of evidence-based frameworks, such as evidence-based medicine and evidence-informed decision-making processes, have frequently been applied within healthcare organisations (Parkhurst, 2018; Buse *et al*., 2024). However, crucial organisational contexts for health and wellbeing promotion, such as schools and workplaces, have been neglected. This paper contributes to filling this gap by exploring cross-sectoral differences in the types of evidence used in an important area of interest for organisations.

For Turner *et al*. (2022), evidence use is shaped by the interactions between individuals and their organisational context and influenced by organisational traditions as well as politics and power relations. In that respect, it is necessary to interpret how evidence is selected and used (or not) in workplaces and schools through both the lens of organisational theory and cross-sectoral evidence use frameworks. As schools and workplaces vary in size, sector, accountability goals, access to resources and organisational constraints, they may face different organisational challenges about evidence selection and use. For instance, calls for the education sector to adopt more data-driven decision-making processes may be challenging due to the diversity of schools and the limited availability of resources (Mandinach and Gummer, 2016). Similarly, calls to implement evidence-based management in workplaces, in which managers should make decisions based on the best available scientific evidence (Rousseau, 2006), may oversimplify managerial work (Morell and Learmonth, 2015; Learmonth and Harding, 2006).

In this review, we adopt a nuanced approach to a problem-solving perspective and evidence-based model (Turner *et al.*, 2022), taking inspiration from Buse’s work on the political nature of health decision-making (Buse *et al.*, 2024) and from the sensemaking theory (Weick, 1995), which explores how individuals interpret their environment to act. Sensemaking includes three stages: perception, interpretation and action. This approach can also help us understand better how evidence is used in relation to health and wellbeing in organisational contexts as diverse as workplaces and schools. This is important because

research on evidence use in organisations is a key part of organisational learning processes, yet studies on evidence use have often focused on improving organisational effectiveness and performance, rather than health and wellbeing. According to Mueller *et al.* (2007: 859), organisational decision-making processes are shaped by socio-political elements, which they define as "decision-makers doing excessive analysis for the purpose of persuasion and communication." The selection (or not) of different forms of evidence by decision-makers can be part of this work of interpretation and analysis, making it a crucial area of interest to understand health and wellbeing investments in workplaces and schools.

2. Methods

A scoping review was used to address the research question "How do workplaces and schools use evidence to allocate resources for health and wellbeing initiatives?" A three-stage procedure, critically assessed and used by Tranfield *et al.* (2003) to be applicable in the field of social sciences and organisations studies, was used, comprising 'planning', 'execution' and 'reporting'. Reporting followed the extended PRISMA guidelines for scoping review (Appendix 1) (Tricco *et al.*, 2018).

In "*planning*" the review, we selected *Assia, Sage Health Journals. Scopus and PubMed* as search engines to ensure a multi-disciplinary focus on organisations, evidence use, and health and wellbeing. To be included, studies needed to focus on health and/or wellbeing promotion, report empirical findings, include some discussion of allocation of the organisation's financial, human or space resources, and some mention of the use (or non-use) of information or evidence in reaching investment (resource allocation) decisions (Table 1). Studies were excluded if: they did not take place in a workplace or school context; they focused only on the effects of health and/or mental health intervention (and not the decision-making process behind the selection of these interventions); they were not in English; and they did not take place in an OECD (Organisation for Economic Co-operation and Development) country, to ensure focus on similar contexts.

In "*executing*" the search, we combined terms related to (1) wellbeing (e.g. health, mental health); (2) organisations (e.g. schools, students, workplaces, employees); (3) investments (e.g. promotion, initiatives); and (4) evidence (e.g. information). An example of a search strategy on *Scopus* can be found in Appendix 2. We also adopted a forward search literature technique which focuses on retrieving relevant original articles or works cited by a study or

Table 1. Key concepts and corresponding inclusion and exclusion criteria

Concept	Included	Excluded
Schools and Workplaces	For schools, any studies taking place in an academy, institution, college, training, university or education setting. For workplaces, any study taking place in organisation(s); business(es); corporations; companies, public, private or third sector, charities, worksites, workspace, workplace, place of work or place of employment	Healthcare organisation describing health investments for patients
Resources-allocation for health and wellbeing promotion	Studies which mention some discussion of priority-setting and, decision-making, about allocation of resources (staffing, money, space) for health and mental wellbeing promotion in a school or workplace context	Studies focusing only on effects or results of health and wellbeing interventions
Evidence	Studies which mention using evidence to inform (or not to inform) decision-making	Studies not mentioning the use of evidence to inform decision-making

relevant document (Couteau, 2014). This enables the identification of relevant studies based on database searches and those obtained through expert knowledge of those publishing in the field.

For the initial research stage, the lead author reviewed all titles and abstracts for relevance, according to the inclusion and exclusion criteria. Three additional raters reviewed a random selection of 5% of titles and abstracts for both workplaces and schools, to assess accuracy of reviews by the lead author. After screening of abstracts and titles, we used a categorisation process to assess the remaining manuscripts for full-text review. Studies were initially sorted into different groups, based on proximity to the research question (Table 2) (Roberts *et al.*, 2002). Studies which were labelled as A1 were included as they met all inclusion criteria for the review.

A data extraction template was used to extract information on (1) study characteristics (authors, date of publication, country); (2) study setting (type of school/workplace), health and wellbeing focus; (3) research methods (e.g. interviews, case studies, secondary data analysis, etc.); (4) resources allocated (e.g. staff, funding, time, etc.); (5) individuals making decisions (e.g. teachers, students, employers, etc.); (6) type of evidence used/discussed (e.g. external research data, internal data, etc.); and (7) ways in which evidence was used.

Following data extraction, a thematic analysis was undertaken to analyse the findings. Themes were developed by the lead author who has a background in sociology and organisation studies, in collaboration with co-authors, who have backgrounds in health economics, health policy, sociology and public health. The lead author first extracted information for all the studies, looking at similarities and differences in terms of type of evidence used, and circulated this information to the co-authors to receive their feedback, interpretation and confirmation. Then, moving back and forth between data and organisational theory on decision-making and evidence (Turner *et al.*, 2022; Weick, 1995; Buse *et al.*, 2024) and together with the co-authors, the lead-author developed three themes to explain the factors leading to evidence use in workplaces and school to inform wellbeing decisions, including ‘context’, ‘having expertise’ and ‘challenging the status quo.’ With the support of the literature

Table 2. Categorisation criteria of selected studies

Initial categorisation of studies	Further categorisation of studies
A. Studies focus on *schools/workplaces,* discuss *health and mental wellbeing promotion and the role of evidence*	1. In-depth discussion of the role of evidence in decision-making about *activities* and how *resources* for these activities are allocated and informed by health and mental wellbeing promotion activities 2. Mention evidence only superficially and do not elaborate on the way report on researchers’ views (theoretical, conceptual, guidelines) on the way it is used to inform decision-making
B. Studies focus on schools/workplaces and health and mental wellbeing promotion and evidence. However, these studies do not rely on empirical evidence	
C. Studies focus on schools/workplaces and health and mental wellbeing promotions, examine how resources are allocated but do not discuss evidence OR vice-versa (studies report on evidence use but do not discuss decision-making about resources allocation)	
D. Studies focus on *health and wellbeing promotion activities*, but do not focus on *schools/workplaces,* do not consider *allocation of resources* to these activities and/or do not consider *evidence* to support allocation of resources to these activities	

review, particularly Buse's attention to the political elements shaping health decision-making (Buse *et al.*, 2024), and Weick's sensemaking theory (Weick, 1995), themes were refined into the final categories of 'expertise' and 'political knowledge.'

3. Results

A total of 8,714 studies were retrieved after removal of duplicates, for both schools and workplaces (see Figure 1). After screening the abstracts and titles, 245 studies were considered of adequate relevance for categorisation and full text assessment. A small number of discrepancies between reviewers were identified and resolved through discussions between the lead reviewer and other co-authors. Those discrepancies related to the way evidence was used (or not) in the studies to inform decision-making processes. After full text review, 74 of the 245 studies were categorised as A (due to the proximity to the research question), of which 27 were categorised as A1 (14 school-based studies and 13 workplace-based studies) and were included in the review (see Table 2).

3.1 Characteristics of the studies

Details of the 14 school-based studies are summarised in Table 3. Studies took place between 2010 and 2024 and in Australia, Austria, Canada, France, Ireland the UK and the USA. Details of the 13 workplace-based studies are summarised in Table 4. Studies took place between 2005 and 2021 in Australia, Canada, Germany, Sweden, the UK and the USA.

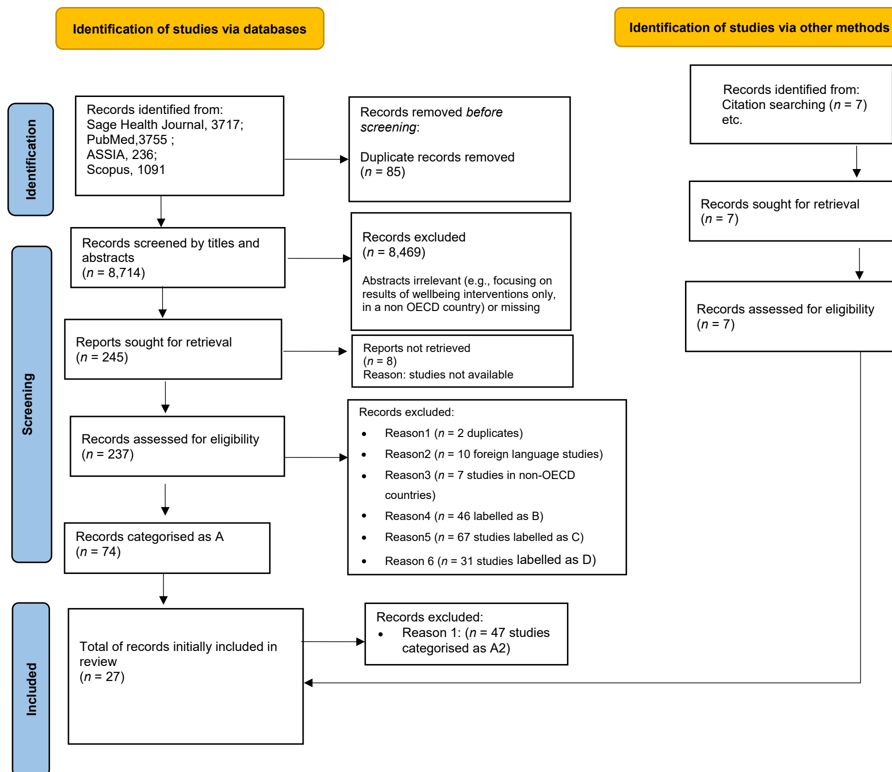

Figure 1. PRISMA diagram

Table 3. Details of school studies

Authors (date of publication)	Setting	Health and wellbeing focus	Research methods	Type of resources allocated	Decision-makers
Adamowitsch *et al.* (2017)	Austria-primary and secondary schools	Health promotion Health behaviour	Interviews	Staff	Headteachers, health coordinators, teachers, municipality representatives
Blackburn and Apesoa-Varano (2019)	Canada-public schools	Coordination of practice across external health services for schools	Interviews	Staff, funding	School board, superintendents, leaders, principals, executive
Breheny *et al.* (2020)	England-unspecified schools	Physical activity	Interviews	Staff, curriculum content	Teachers, leadership staff
Brown *et al.* (2018)	Canada-unspecified school	Health behaviour	Interviews	Staff	Teachers, vice-principals
Cygan *et al.* (2020)	USA-primary schools	Physical activity and nutrition policies	Interviews	Staff and funding	Teachers, principal, School Health Administrators
Jessiman *et al.* (2019)	England-academies	Health behaviour	Interviews	Staff, staff training, technology equipment	Academy and school leaders
Meiklejohn *et al.* (2021)	Australia-secondary school	Health behaviour	Case study	Staff	Teachers, students, principals
Morris and Dobson (2021)	England- mix of schools	No defined focus	Interviews	Staff, funding	School leaders, school governors
Ozer *et al.* (2010)	USA-secondary schools	Wellbeing	Interviews	Staff, technology equipment	Teachers, program developers
Phillips and Martinez (2010)	Canada-public and Catholic schools	Sexual health	Interviews	Staff, curriculum content	Teachers
Pommier *et al.* (2011)	France-primary schools	Health behaviour	Case study	Staff	School representatives, parents' representatives, regional actors
Storey *et al.* (2016)	Canada-unspecified school	School health	Secondary analysis	Staff, funding	School health facilitators, teachers, school principals
Higgins and Booker (2022)	Ireland- primary and post-primary schools	Mental Health and Wellbeing promotion Access to external professional services, and access to evidence-based interventions and practices	Case studies	Staff, funding	principal, vice-principal, Home School Community Liaison Co-Ordinator, assistant psychologist and family support workers
Sulz *et al.* (2016)	Canada-unspecified school	Health behaviours	Focus group interviews	Staff	Teachers

Table 4. Details of workplace studies

Authors (date of publication)	Setting	Health and wellbeing focus	Research methods	Type of resources	Decision-makers
Baril-Gingras and Dubois-Ouellet (2018)	Canada-multiple sectors	Health and safety promotion	Interviews	Time for employee representatives	Trade union leaders/ representatives, employers
Cole *et al.* (2005)	Canada-health	Quality of work life	Case studies	Budget allocations	Human resources (HRs) teams
Hall *et al.* (2006)	Canada-auto parts plants	Health and safety promotion	Interviews	Money, staff	Managers, trade union representatives
Hughes *et al.* (2011)	USA-multiple sectors	Health insurers informing health promotion programs	Interviews	Time and money	Employers, HR managers, trade union
Larsson *et al.* (2016)	Sweden-municipal government	Health and safety promotion	Interviews	Time	HR, senior managers
Marsh *et al.* (2018)	Australia-multiple sectors	Health and wellbeing	Interviews	Information	Industry association representatives
Miller and Haslam (2009)	UK-multiple sectors	Occupational health and wellbeing promotion	Interviews	Money	Occupational health and safety professionals
Nelson *et al.* (2015)	USA-multiple sectors	Workplace health promotion	Interviews	Money, Staff	HR, occupational health specialists, senior managers, employees
Pavlista *et al.* (2021)	Germany-small and medium companies	Psychosocial risks prevention	Interviews	Limited financial and human resources	Employers and managers
Quirk *et al.* (2018)	UK-public hospital	Health and wellbeing promotion	Interviews	Limited financial and human resources, government funding	Senior leaders, wellbeing practitioners, HR
Rohlman *et al.* (2018)	USA-small and medium companies	Health and wellness promotion	Case studies	Limited financial and human resources	Safety managers, and HR directors
Witt *et al.* (2013)	USA-small and medium companies	Health promotion	interviews	Money, staff	Executives, internal health and wellness committees, senior HR personnel
Leso *et al.* (2024)	USA-mining, construction real estate, healthcare and other sectors	Organisational based Total Workers' Health initiatives	Secondary data analysis	Time for meetings, having sufficient staff to participate in the programs, funding, workload	Leaders, HR managers and workers

All schools invested in staff resources, training or use of existing staff time to support student wellbeing. 36% of studies reported explicitly the use of money to invest in wellbeing programmes, with 14% of studies specifying investment in technological equipment and 14% of studies highlighting time investment in development of curriculum content. In addition, some schools facilitated access to a skilled health promotion stakeholder (Higgins and Booker, 2022; Philips and Martinez, 2010).

The key decision-makers were school leaders, principals or head teachers. The role of the decision-maker was influenced by the context and traditions in which the study was taking place. For instance, one study in France (Pommier *et al.*, 2011) emphasised that due to the history of the French school system, the role of parents as decision-makers was not well-recognised. Conversely, a study taking place in England emphasised the influence of school governors on the school decision-making process, some of them being parents (Morris and Dobson, 2021).

For workplaces, all studies focused on the implementation or promotion of health, safety and mental health initiatives. In one study, health and safety was explicitly prioritised over mental health (Pavlista *et al.*, 2021). Larsson *et al.* (2016) suggested that countries adopted different definitions of workplace health promotion, with health promotion tending to be considered as individuals' wellness and health behaviour in the United States while in European countries, a broader view of workplace health promotion incorporated the quality of the work environment and conditions as important factors for employee wellbeing. In some US studies, however, the resources allocated to health and wellbeing promotion relied as much on employees' input and needs regarding their work conditions and experiences, through trade unions and wellness committees, than health packages proposed by insurance brokers (Hugues *et al.*, 2011; Witt *et al.*, 2013).

For studies on workplaces, there was some variation over the role and importance of decision-makers. A majority focused on the role of senior management as key decision-makers. However, the importance of other key actors varied by country. For example, in Sweden, there was a specific emphasis on employee participation (Larsson *et al.*, 2016), and this was presented as a legal requirement. This emphasis on employee participation was also present in a study located in Germany. In studies based in the UK, US and Canada, decision-making seemed to rely primarily on senior managers (Witt *et al.*, 2013; Hughes *et al.*, 2011; Nelson *et al.*, 2015), and the use of employees" feedback was dependent on the presence and power of the voice of employees' representatives (Hugues *et al.*, 2011; Nelson *et al.*, 2015; Witt *et al.*, 2013).

3.2 Types of evidence used in schools and workplaces

Three broad types of evidence used in the studies were identified. First, '*external research data*', which included evidence produced outside the school or organisation, such as academic research on the effectiveness or cost-effectiveness of health and wellbeing programmes. Second, '*internally generated data*', which is evidence generated within the school or workplace organisation. This included informal evaluation of initiatives as well as research findings produced through surveys, interviews and observations within the organisation. Third, '*external expertise*', which constitutes information provided by stakeholders outside the school or organisation with skills or knowledge influencing the school or workplace decision-making (e.g. public health partners, consultants, etc). Study participants within the organisations (teachers, managers, workers) also reported the use of their own skills, experiences and insights to make decisions.

To inform their decisions, all school studies reported using their skills, knowledge or experiences to make decisions. 36% of studies used these in combination with external research data, 43% with the support of internally collected data (e.g. survey, informal evaluation) and 57% with inputs from external experts. Most school studies (70%) highlighted restricted human and time resources to support access to varied forms of evidence. For

example, one study (Adamowitsch *et al.*, 2017) mentioned that teachers lacked time and financial resources to take part in the evidence-gathering, and therefore it was down to the head teacher to find time to look for research or scientific evidence related to health and wellbeing, use internal data and make decisions based on what was found. Other studies emphasised a lack of specialist staff who could investigate evidence about health, for example school nurses (Cygan *et al.*, 2020). Higgins and Booker (2022) noted that schools had to rely on their own funds to hire external experts, such as mental health speakers.

In workplace studies, most organisations reported using their insights and experiences to make a decision (77%). However, the use of external experts was more commonly described in studies of workplaces than in studies of schools. For instance, 77% of workplace studies used external expertise such as consultants, compared with 57% of school studies. Like schools' studies, however, resources for identifying and using evidence were often limited. Many studies mentioned insufficient human resources, lack of internal skills to analyse data systematically, or inappropriate survey instruments to collect internal data upon which to base their decisions (Pavlista *et al.*, 2021; Quirk *et al.*, 2018; Larsson *et al.*, 2016; Miller and Haslam, 2009) (see Table 5).

We generated three themes based on the data extracted to explain how schools and workplaces used evidence to invest in health and wellbeing. These were:

(1) *Evidence-based provision adapted to context*, which looks at how evidence is used or not used in tandem with context of the decision;

(2) *Having expertise*, which reports decision-makers seeking expertise in their selection of evidence or reliance on their experiences to make a decision related to health and wellbeing;

(3) *Challenging the status quo*, which shows instances where evidence could be used to challenge decision-making or current wellbeing practice.

3.2.1 Evidence-based provision adapted by context. A key emerging theme was the importance of organisational context of schools and workplaces. Context appeared to be an important moderator for the use of different forms of evidence. For example, studies highlighted the importance of teachers' insight in adapting expert-recommended health and wellbeing activities to their diverse classrooms, so these activities would be relevant to their students' experiences (Ozer *et al.*, 2010; Higgins and Booker, 2022). A second school-based study highlighted the fact that teachers needed to critically review the evidence available to them and decide which forms of evidence were the most likely to be actionable in their classroom context (Pommier *et al.*, 2011).

In workplaces, there was a similar emphasis on the importance of context. Industry actors in the Marsh *et al.* (2018) study argued that there was a need to re-shape the language and appropriateness of health promotional materials, business cases and resources according to the industry sector they represented. In Leso *et al.* (2024), the success of health-related interventions relied on leaders' abilities to engage with their workforce to identify and specifically target priority areas, such as ergonomic risks, injuries and noise risks. Pavlista *et al.* (2021), Rohlman *et al.* (2018) and Witt *et al.* (2013) emphasised that decision-makers often looked for wellbeing activities or programmes relevant for the size of their organisation but often struggled to find appropriate evidence and tools. For example, in Pavlista *et al.* (2021), the lack of an appropriate health and safety surveys for small organisations was a problem in relation to the identification of relevant data.

The context could sometimes constrain the use of a variety of evidence. In one school-based study, religious beliefs influenced the way schools allocated resources to their sexual health teaching courses (Phillips and Martinez, 2010). Other school studies (Cygan *et al.*, 2020; Adamowitsch *et al.*, 2017) emphasised the importance of cultural practices and traditions in a

Table 5. Evidence and experiences use in school-based studies

		Types of evidence and experiences used				Way in which evidence and experiences were used		
Authors (date of publication)	Context	External research data	Internally generated data	External expertise	Experiences, and insights skills	Evidence-based provision adapted by context	To have expertise	To challenge the status quo
Meiklejohn *et al.* (2021)	Australia-secondary and public school	Y	N	N	Y	Y	N	N
Adamowitsch *et al.* (2017)	Austria-primary, secondary schools	N	Y	N	Y	Y	Y	Y
Brown *et al.* (2018)	Canada-schools unspecified	N	Y	Y	Y	Y	N	N
Blackburn and Apesoa-Varano (2019)	Canada-public schools	N	N	Y	Y	Y	Y	N
Phillips and Martinez (2010)	Canada-public and Catholic schools	N	N	Y	Y	Y	N	N
Storey *et al.* (2016)	Canada-school unspecified	N	Y	N	Y	Y	Y	N
Sulz *et al.* (2016)	Canada-school unspecified	Y	N	N	Y	Y	N	N
Breheny *et al.* (2020)	England- unspecified schools	N	N	N	Y	Y	Y	N
Jessiman *et al.* (2019)	England-academies	N	N	Y	Y	Y	Y	N
Morris and Dobson, 2021)	England-mix of schools	N	Y	N	Y	Y	Y	N
Pommier *et al.* (2011)	France-primary schools	Y	Y	Y	Y	Y	Y	N
Cygan *et al.* (2020)	USA primary schools'	N	N	Y	Y	Y	Y	Y
Ozer *et al.* (2010)	USA-secondary schools	Y	N	Y	Y	Y	N	N
Higgins and Booker (2022)	Irish- primary and post primary schools	Y	Y	Y	Y	Y	Y	Y

Note(s): Y=Yes; N=No

particular context which may hinder or facilitate the implementation of new health practices. It was noted that the broader institutional context also played a role in the use of certain forms of evidence over others, such as cost-benefit evidence. In both workplaces and schools, studies in the US, UK and Ireland highlighted the costs and benefits of interventions as the most important evidence for decision-makers (Miller and Haslam, 2009; Hughes *et al.*, 2011; Leso *et al.*, 2024) (see Table 6).

3.2.2 Having expertise. The second theme describes tensions over what is interpreted and defined as expertise by decision-makers in their selection of evidence or reliance on their experiences to make a decision. In many cases, schools' reliance on their professional skills, experience and insights were essential to the implementation of health initiatives (Meiklejohn *et al.*, 2021; Adamowitsch *et al.*, 2017; Brown *et al.*, 2018), such as putting in place their own internal referral systems (Higgins and Booker, 2022). Yet findings also crucially emphasised the need to access external resources, such as guidance and support from external professionals, and the efforts from schools to bring in speakers on mental health, even though access was often limited due to a lack of funding (Higgins and Booker, 2022).

Challenges around the constitution of expertise also emerged in workplaces. A perceived lack of expertise (e.g. human resources) meant that internal data were often not analysed extensively (Larsson *et al.*, 2016; Rohlman *et al.*, 2018). Miller and Haslam (2009) highlighted a perceived lack of robust empirical data to accompany business cases about investment in health in organisations, with a preference for intuitive, emotional and ethical arguments to drive organisational actions. However, when health-related information was framed as specialist knowledge, decision-makers often felt they lacked time or legitimacy to analyse organisational data related to their employees' health status. This discourse about a lack of organisational expertise for using evidence meant that workplaces often used shortcuts, such as easy and low-cost interventions, as noted by Rohlman *et al.* (2018), or calling external experts to deliver talks or transfer information (Quirk *et al.*, 2018; Marsh *et al.*, 2018; Witt *et al.*, 2013; Nelson *et al.*, 2015). Training possibilities for workers was also another opportunity to increase organisational expertise, such as workers' knowledge and expertise about the health and safety risks of their occupation, but the Leso *et al.* (2024) review indicates that such training was often not sustained continuously. On the other hand, using external expertise, such as external consultants, could also be a way to depoliticise sensitive issues. For example, calling in experts was not only seen as an easy way to promote health and wellbeing, but also as a neutral way to increase workers' acceptance of interventions (Pavlista *et al.*, 2021).

3.2.3 Challenging the status quo. Finally, evidence could also be used to challenge decision-making, or employers' or headteachers' decision-making. For example, Adamowitsch *et al.* (2017) note that the headteacher could become the target of persuasion strategies by other staff to encourage them to look at different forms of evidence (Cygan *et al.*, 2020) or ideas (Adamowitsch *et al.*, 2017) in relation to resource allocation and the implementation of health interventions (e.g. convincing the headteacher to allocate funding for a specific intervention). Evidence for wellbeing interventions also helped challenge the academic-based performance focus, according to some studies (Higgins and Booker, 2022).

In workplaces, Baril-Gingras and Dubois-Ouellet (2018) and Hall *et al.* (2006) demonstrated that knowledge about health and safety (such as specialist research on health and work conditions from books, web sources and personal and professional contacts) could be transformed into 'knowledge activism' by trade union and employee representatives to push for improvements in health and safety practices in their workplaces. This alternative use of evidence by employees could then encourage management to allocate resources to new safety areas (e.g. investing money in more preventive equipment). In Hall *et al.* (2006), a health and safety committee gathered specialised clinical knowledge about the danger of a lack of ventilation and lighting when using machines, pushing the company to invest large sums of money in a new ventilation system.

Table 6. Evidence and experiences use in workplaces studies

Authors (date of publication)	Context	Evidence and experiences				Use of evidence and experiences		
		External research data	Internally generated data	External expertise	Experiences, insights and skills	Evidence-based provision adapted to context	To have expertise	To challenge the status quo
Marsh *et al.* (2018)	Australia– multiple sectors	Y	N	N	N	Y	N	N
Baril-Gingras and Dubois-Ouellet (2018)	Canada-multiple sectors	Y	Y	Y	Y	Y	Y	Y
Cole *et al.* (2005)	Canada-health sector	Y	Y	N	Y	Y	Y	N
Hall *et al.* (2006)	Canada-auto parts plants	Y	Y	Y	Y	Y	Y	Y
Pavlista *et al.* (2021)	Germany-small and medium companies	N	Y	Y	Y	Y	N	N
Larsson *et al.* (2016)	Sweden-municipal government	N	Y	Y	Y	Y	N	N
Miller and Haslam (2009)	UK- multiple sectors	N	Y	N	Y	Y	N	N
Quirk *et al.* (2018)	UK-National Health Service	N	Y	Y	Y	Y	Y	N
Hughes *et al.* (2011)	USA-multiple sectors	N	N	Y	N	Y	N	N
Nelson *et al.* (2015)	USA-manufacturing industries	N	N	Y	Y	Y	N	N
Rohlman *et al.* (2018)	USA-small and medium companies	N	Y	Y	N	Y	N	N
Witt *et al.* (2013)	USA-small and medium companies	N	Y	Y	Y	Y	N	N
Leso *et al.* (2024)	USA- mining, construction real estate, healthcare and other sectors.	Y	Y	Y	Y	Y	Y	Y

Note(s): Y = Yes; N = No

4. Discussion

4.1 Key findings

Findings from this review demonstrate that workplaces and schools seek evidence to develop their health and wellbeing expertise while addressing organisational needs and interests, in a context of limited resources. Schools relied heavily on their internal insights and experiences to inform and justify their decision-making. For workplaces, although many employers engaged with their internal data, studies showed that they often perceived they lacked the necessary expertise (e.g. human resources) to make efficient decisions about health and wellbeing investments in the context of their organisation and tended to engage also with forms of external expertise as a consequence. Findings highlight that evidence utilisation and search for expertise is affected by power dynamics and hierarchies of decision-making processes. The hierarchical nature of the school-setting, for instance, meant that headteachers or principals were the main decision-makers, while in workplaces, this was the case for senior-management. Yet, evidence use was regularly used as way to subvert this power asymmetry in the decision-making process in schools and workplaces, and highlighted the key role played by other actors in education and workplace settings.

4.2 Comparison to existing literature and explanation of findings

Institutional, organisational and political processes shape schools' and workplaces' perception of evidence types, leading to prioritisation of some forms of evidence over others to inform their decisions about health and wellbeing investments. In this aspect, the findings of this review echo other research focusing on priority setting in specific organisational contexts demonstrating how institutional, political and cultural factors play a role in influencing decision-making processes (Lessard *et al.*, 2010; Eddama and Coast, 2009), particularly in the area of health (Buse *et al.*, 2024). Through the combined lenses of Turner's nuanced problem-solving approach and evidence use (Turner *et al.*, 2022) and sensemaking theory (Weick, 1995), we found that schools and workplaces similarly prioritised looking for evidence which they interpreted as fitting their organisational needs for expertise – or perceived lack of expertise. Such search for expertise could also be due to the growing importance given to workplaces and schools as places for health promotion outside traditional healthcare organisations.

Experience could operate as a moderator of the use of other forms of research and external evidence, as has been shown in previous studies focused on general evidence use in education settings (Barwick *et al.*, 2014; Neal *et al.*, 2018). Schools may also favour their internal insights for wellbeing investments because, despite taking on growing wellbeing responsibilities, they receive limited external resources and support (Hanley *et al.*, 2020) to interpret and use different forms of evidence. In the context of workplaces, the lack of "expertise" perceived by workplace decision-makers echoes Kowalski and Loretto (2017) who point out the challenges of adopting a holistic approach to wellbeing in the workplace due to limited resources and priority given to focus on employees' performance, rather than their wellbeing needs.

We also found that evidence could be used as way to challenge or advocate for a particular intervention in some instances, transforming a technical form of knowledge into a form of "political knowledge" to push for changes (Carlan *et al.*, 2022), rather than seeing evidence as a managerialist tool (Learmonth and Harding, 2006). For instance, evidence gathered about the importance of students' health and wellbeing could help challenge the over-emphasis on academic-based performance in schools (Higgins and Booker, 2022). As noted by Turner *et al.* (2022), further research is needed on how professional power and conflict inform and shape evidence use in decision-making. Such diverging power interests and potential conflicts were clearly present in how schools and workplaces used evidence in their decision-making process.

In workplace studies, there were divergent power interests between employers and employees. Here, the use of external evidence (such as involving external consultants) could "neutralise" this power divergence or challenge the management position (Hall *et al.*, 2006; Baril Gingras and Dubois-Ouellet (2018). Consequently, rather than being a "threat" to

democratic processes and pluralism in workplaces (Learmonth and Harding, 2006), the use of evidence from different parts of the organisation may reinforce democratic forms of decision-making in the workplace and contribute to positive politics (Parmentier and Reynaud, 2022). In this way, our findings contribute to a better understanding of how the development of technical knowledge can enhance existing knowledge and support political activism (Carlan *et al*., 2022), for instance by representing an opportunity to bargain for collaborative evidence-based health and safety initiatives in the workplace and better consistency of approaches across workplaces and sectors.

4.3 Implications of findings

Our review highlights the important political role of evidence use in affecting organisational decision-making and demonstrates how recognising multiple forms of evidence in organisations could potentially improve transparency and democracy of decision-making processes in this area. On a practical note, researchers producing evaluations about wellbeing initiatives should consider the best way their evaluations can be made available to various organisational actors taking part in relevant decision-making processes (managers and employee representatives, for instance). This could be particularly relevant regarding the effectiveness of digital tools for the support of wellbeing in schools and workplaces which have become increasingly available (Henstock *et al*., 2025; Dagenais *et al*., 2022; Sakellari *et al*., 2021) and may be relevant within certain organisational processes (Cameron *et al*., 2025). In addition, researchers should also consider how the context and dynamics of these organisations enables organisational actors to access and use different forms of evidence. For example, this might take the form of policy-driven initiatives to build capacity for understanding and interpreting the implications of wellbeing programmes for use in schools and workplaces, and to consider the effects of combining different forms of evidence for implementing effective wellbeing innovations in schools and workplaces.

4.4 Limitations and strengths

Our review has some limitations. The number of studies does not allow us to generalise the way schools and workplaces use evidence. Many of our workplace studies focused on small- and medium-sized businesses, where the process of decision-making and availability of human and time resources may differ from larger organisations. Similarly, there are a wide range of school types that are funded and managed in different ways across, as well as within, countries. The selected studies did not explore differences between diverse types of schools. The empirical studies in this review rarely focused on resource allocation or evidence use as their primary objective, and this was reflected in the diverse materials and findings in the extraction. Finally, our findings only reflect processes of evidence-use in workplaces and schools for wellbeing activities in the context of OECD countries. On the other hand, we synthesise these findings thematically, comparing schools and workplaces and in doing so identifying new insights about how these organisations approached evidence in relation to health and wellbeing.

4.5 Further work

The review findings offer some further avenues to explore. First, there is the need to better understand how different forms of evidence affect resource allocation in these settings, as current studies rarely focused on this issue yet evidence-based investment is increasingly desired by policymakers. The issues to investigate include the degree to which internally (compared to externally) generated evidence is sought and used by decision-makers in schools and workplaces. Economic evaluation (cost-effectiveness) evidence presents the additional costs and benefits of an investment in standardised units and therefore enables decision-makers to examine the value-for-money of different interventions. More research is needed to

understand how such data are interpreted in these settings and how such evidence could be designed and communicated most effectively to school and workplace decision-makers. A future research agenda also includes a need to explore in more depth how specific political and institutional contexts influence workplaces and schools' use of (and access to) evidence, in and beyond OECD countries and larger workplaces. Similarly, there is a need for empirical studies to be led on the way different organisational processes and dynamics shape evidence use, and how organisational theory can help us understand better these issues.

5. Conclusion

The ways that schools and workplaces use evidence to invest in health and wellbeing are shaped by their contextual needs, what they perceive as expertise, and the power interests at play between decision-makers and the rest of the organisation. Schools place particular importance on building their internal expertise through experiences and skills, while workplaces tended to engage with a variety of forms of evidence, both internal and external. Both schools' and workplaces' use of evidence can also become a form of political knowledge to challenge decision-making processes. There are implications for the role of the research community, as research produced to improve health and wellbeing in these settings needs to be sensitive to how these important factors influence decision-making processes.

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Appendix 1

Table A1. Preferred reporting items for systematic reviews and meta-analyses extension for scoping reviews (PRISMA-ScR) checklist

Section	ITEM	PRISMA-ScR checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a scoping review	1
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives	1
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach	1–3
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g. population or participants, concepts, and context) or other relevant key elements used to conceptualise the review questions and/or objectives	3
METHODS			

(*continued*)

Table A1. Continued

Section	ITEM	PRISMA-ScR checklist item	Reported on page #
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g. a Web address); and if available, provide registration information, including the registration number	3–4
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g. years considered, language, and publication status), and provide a rationale	3–4
Information sources*	7	Describe all information sources in the search (e.g. databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed	3–4
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated	3–4
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e. screening and eligibility) included in the scoping review	3–4
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g. calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators	3–4
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made	3–4
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate)	3
Synthesis of results	13	Describe the methods of handling and summarising the data that were charted	3–4
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram	4–8
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations	4–8
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12)	8–9
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives	4–8
Synthesis of results	18	Summarise and/or present the charting results as they relate to the review questions and objectives	4–8
DISCUSSION			
Summary of evidence	19	Summarise the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups	9–14
Limitations	20	Discuss the limitations of the scoping review process	15

(*continued*)

Table A1. Continued

Section	ITEM	PRISMA-ScR checklist item	Reported on page #
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps	15
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review	N/A

Source(s): Tricco *et al*. (2018)

Appendix 2

(1) *Search on Scopus database for SCHOOLS:*

(*schools** OR *education** OR *academy* OR *college* OR *university* AND *students* OR *pupils*) AND (*mental* AND *health* OR *physical* AND *health* OR *wellbeing** OR *wellbeing* AND *pro motion* OR *wellness* OR *psychosocial* OR *psychological*) AND (*investment* OR *decision* AN D - *making* OR *managing** OR *allocation** OR *resources** OR *time* AND *budget** OR *funds*) A ND (*evidence* OR *science* OR *research* OR *information* OR *experiences* OR *data* OR *results* OR *knowledge** OR *costs-benefits* OR *costs-effectiveness**)

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