Mental Health and Wellbeing in the Workplace: A Comparative Study of Employers’ and Employees’ Perspectives

By
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Abstract

Mental Health and wellbeing has become an area of increasing interest to UK employers as the effects of poor employee mental health can be detrimental not only for affected employees but also to the business. Despite the importance of managing employee mental health in the workplace being largely recognized nowadays, many employers still feel like they need more support in the area. In addition to this, while stress has been widely discussed in relation to the workplace, the management of mental health conditions in the workplace and unique issues attached to this – such as stigmatization – have only been considered rarely.

Thus, this research aims at understanding both employers’ and employees’ perceptions around how MH and wellbeing can be fostered within an organization and what the most effective initiatives are to enable a discussion around MH and in turn decrease stigmatization thereof. By using a concurrent mixed-methods approach consisting of interviews and an online questionnaire, this research project was able to explore different themes and contribute to existent literature. The findings underline the importance of a transparent and open culture as well as management support in order to foster a discussion of mental health in the workplace. Moreover, employees found flexible working arrangements to be most effective in relation to good mental health and wellbeing while participating employers underlined offering specific resources for employees with a mental health problem to foster inclusion. Line management training has moreover been identified as critical to improve managers’ ability to recognize early symptoms of mental health conditions and in turn foster employee wellbeing. Recommendations for organizations on how to manage employee mental health are outlined in relation to this project’s findings.

Key words: Mental Health, Wellbeing, Organizational Practices and Policies, Management Training
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<td>MH</td>
<td>Mental Health</td>
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<td>MHC</td>
<td>Mental Health Condition</td>
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<td>MHCs</td>
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<td>P&amp;Ps</td>
<td>Practices and Policies</td>
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<td>BOS</td>
<td>Bristol Online Survey</td>
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<td>IBM SPSS</td>
<td>Statistical Package for the Social Sciences</td>
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## Statistical Abbreviations

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<tr>
<td>M</td>
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<td>SD</td>
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<td>p</td>
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1. Introduction

In recent times, the general public has become largely aware of different mental health conditions (MHCs), yet despite this increasing awareness, mental health problems remain heavily stigmatized. Looking at statistics of common MHCs – depression and anxiety disorders being the most common ones – within the Western world, it becomes clear that a large number of people are affected by it. Within the United Kingdom, 1 out of 4 people will experience a mental health problem any given year and from these, 9 out of 10 experience some form of stigma and discrimination (Mental Health Foundation, 2016). In relation to the labour market, this mental health burden has a significant effect on UK businesses with the Labour Force Survey estimating a total of 440,000 reports of work related stress, depression or anxiety and in effect 9.9 million working days lost in 2014/2015 alone (HSE, 2015).

The clinical picture of MHCs or disorders often entails physical and psychological effects or symptoms and it can be difficult to decipher when a mental health problem arises, how it will progress or affect the individual (Goldberg & Huxley, 1992). Hence, mental health (MH) is a complex topic and it is important to consider that stress, wellbeing and MH are often used interchangeably – not least by employers in relation to practices and policies (P&Ps) to aid employees (Shutler-Jones & Tideswell, 2011). While (work-) related stress is essential to the discussion around MH and wellbeing, it is important to note that stress in itself is not considered a MHC. Although, prolonged experience of stress can lead to psychological conditions (NICE, 2009). While this thesis generally refers to MHCs, it is vital to acknowledge that the terms imply a number of conditions varying in severity.

Nevertheless, all MHCs, as well as stress, significantly impact personal and professional lives – and are in turn affecting employers. In the workplace, depression is considered the most common mental illness, followed by other effective or mood and anxiety disorders, as well as substance abuse (Schott, 1999; Wheat et al., 2010). These conditions pose a great financial burden on employers since employees suffering from a mental health condition may not be able to perform as effectively. As Stewart et al (2003) note, depression alone makes up for 81% of lost productive time within the United States of America. One of the most commonly listed effects of MH problems in the workplace is absenteeism, which describes phases of absence due to (mental) ill health (Baker-McClear
et al, 2010). Yet, while MH problems can impair employees’ ability to come into work and hence account for a significant loss in working days, it is important to underline that mental ill health also interferes with their productivity when they show up. As underlined by Caverley et al (2007), research marks a shift in awareness from absenteeism towards presenteeism – which describes the situation of employees coming into work despite their (mental) health condition. Presenteeism can be immensely damaging for employers as well as employees given that the CIPD estimates the quota of productivity loss as well as chances of burnout 7.5 times higher in cases of presenteeism as opposed to absenteeism (Baker-McClearn et al, 2010).

While this underlines the detrimental effects of mental ill health to both individuals as well as employers, many employers may not know if their employees are suffering from a MHC. Henderson, Williams, Little and Thornicroft (2013) found that in 2006, 1/3rd of UK employers claimed that none of their employees suffered from mental health problems, while 80% had no formal policy and noted that they required more support on how to handle these issues.

It is possible to assume that the lack of appropriate awareness goes hand in hand with the likelihood of people concealing their condition as statistically only slightly over 20% of those suffering from mental illnesses seek professional help due to fear of stigmatization (Schott, 1999; Wheat et al., 2010). Mental health stigma (MHS) significantly undermines the quality of the lives of those affected as it labels them as ‘different’, possibly dangerous or unstable and leads to fewer opportunities for interpersonal relationships, employment, housing etc. (Corrigan, 2007; Link et al, 1999; Corrigan et al., 2001). Stigmatization and the fear of being stigmatized hence often lead to concealment, in turn alienating those suffering from a MHC and allowing for their condition to progress. For the labour market, this means steady numbers of burnout, presenteeism, and absenteeism.

1.1 Relevance of Research

The detrimental effects of poor MH and wellbeing of employees in the workplace are largely recognized and the majority of British employers express the need for more support in the area (Brohan et al, 2010; Henderson et al, 2013). Looking at employees’ perceptions, one in five employees feels that their organization does not support employees with a MHC well or not at all, and only 38% believe that their organization has
an inclusive environment, which fosters discussion around MH (CIPD, 2016), underlining the relevance of the subject matter.

Moreover, while research has largely covered stress and its effects on employees, it is vital to recognize that MHCs – albeit related to stress - as separate and significant issue in relation to the workplace, that ought to be researched in more depth. The role of stigma in the context of the workplace has also only been researched rarely; hence this dissertation seeks to bridge this gap and contribute to existent research by comparing and contrasting employers’ and employees’ perspectives around the prevalence of MHCs in the workplace, the effects of MHS and the evaluation of P&Ps that are aimed at protecting MH and wellbeing in the workplace.

1.2 Research Objective

This research evolves around understanding what employers can do to prevent and cope with cases of MHCs such as anxiety or depression and their effects such as burnout, absenteeism or presenteeism. It aims at understanding what employers are doing to address issues around stigmatization and support employees with MHCs within their organizational culture. This research seeks to understand employees’ experience of these practices and their impressions of their employers’ efforts to care for their (mental) wellbeing. As this project is sponsored by a Social Enterprise focusing on this field, the subsequent research objective is to formulate recommendations on the measures employers can take in this respect.
2. Literature Review
The following literature review will begin with an overview of MH and wellbeing in the workplace and discuss the prevalence of MHCs in the workplace as well as their interplay with (an overload) of work stressors. Subsequently, MH will be conceptualized in the context of stigmatization, followed by a discussion of underlying perceptions and attitudes towards MHCs, and their consequences and implications. In connection to this, the arguments around disclosure of mental health problems and its effects within the labor market will be assessed. This section then ends with a discussion of common practices aimed at addressing MH problems and increasing employee wellbeing as well as line management’s and HR’s role in delivering these practices.

2.1 Mental Health in the Workplace
People suffering from a MHC face significant challenges in terms of participation and quality of life (Corrigan et al, 2001). Boardman (2011) points to social exclusion of people with a MHC within the UK – differentiating between different domains of exclusion ranging from consumption, service exclusion (private and health services in particular) and exclusion from social interactions. While Boardman (2011) also rightfully notes that social exclusion cannot be generalized, as people with a mental health problem are not a homogeneous group, it is possible to state that individuals who suffer from a MH problem may face unique challenges when it comes to the workplace, both pre- and during employment.

While most MHCs are chronic and entail an immense financial burden, individuals with a serious MHC earn approximately 1/3rd less than non-affected people according to the WHO (Sickel, Seacat & Nabors, 2014). Overall, MHCs are associated with the strongest stigma ratings, lower income and lowest employability ratings in comparison to general medical conditions (Baldwin & Marcus, 2006). Apart from higher unemployment rates, depression for instance, is moreover associated with decreasing productivity and in turn higher risk of presenteeism, greater absence rates and overall costs for organizations (Lerner & Henke, 2008).
Overall, there appears to be an increasing awareness among the majority of British companies that they are losing talent because they are not adequately equipped to deal with employee mental health problems (Henderson et al, 2013). When it comes to MH in the workplace, it is important to look not only at how employers are treating people with a pre-existing MHC, but also how employment conditions, such as workload or cultural climate, interact with employees’ mental wellbeing and to what extent they facilitate or moderate it.

2.1.1 Work-Related (Mental) Health Problems – Job Stressors

While it is important to consider stress as a separate entity from MHCs, they are interlinked as (work) stressors can significantly attribute to or even cause MH issues (Iacovides et al, 2003). Hence, it is important to understand people’s work environment and analyse how work stressors tie into the discussion around MH and wellbeing in the workplace.

Due to technological advances and rapidly growing global competition and unpredictable fads and fashions, organizations are constantly evolving and changing (Kew & Stredwick, 2013). Hence, modern work environment has become increasingly competitive and unstable, yet greater demands are imposed on employees to perform and adapt to changes while job security is seldom guaranteed – which can easily lead to significant increases in stress (Loretto, Platt & Popham, 2010). In turn, high levels of stress and insecurity can quickly result in an increase in cases of burnouts, spike depression and anxiety rates as well as enhance the likelihood of substance abuse (Tennant, 2001).

When looking at work stress, it is important to highlight that it differs from personal stress as people are limited in their opportunities to cope with it and are arguably under greater pressure to meet work-related demands as well as organizational pressures (Iacovides et al, 2003; Collins & Cartwright, 2012). In addition to this, work stressors are often only understood correctly after, for instance, depression, or burnout is diagnosed (Tennant, 2001). Clark et al. (2012) - who underline that prevention of MH problems and promotion of wellbeing ought to be the priority for UK work population - analyzed the interaction between work and non-work stressors and their relationship with MHCs. Clark et al (2012) found that work and non-work stressors impact common mental disorders independently, it is nonetheless vital to consider both these spheres – especially given
that modern technology has blurred the lines between home and work in many jobs. In terms of non-work stressors, the most crucial factors appear to be financial security, support through personal networks, life events (Clark et al, 2012; Collins & Cartwright, 2012) – and most significantly the illness of a close relative (Clark et al, 2012).

In relation to job stressors, the NICE (2009) distinguishes between sources of stress arising out of the work context – such as management style, organizational justice, participation or perceived support – and the work content, which involves factors such as effort and reward, the role, or work demand and control. Clark et al (2012) moreover found the strongest association between over-commitment and common MHCs, which proves consistent with other studies (Collins & Cartwright, 2012). Underlining the link between stress and MHCs, work-related stress, anxiety and depression were all found to largely be rooted in workload pressures, tight deadlines, overwhelming responsibility and lack of or poor managerial support (HSE, 2015).

Overall, when analyzing job stressors in the context of MH and wellbeing, it is important to consider three things. Firstly, that most of the aspects outlined here are out of employees’ control and secondly, that job stressors may differ between different sectors, employee groups and industries (Tennant, 2001). Thirdly, intersections between stress and occurrence and progression of MHCs are a highly complex matter that most likely works differently for each individual and hence generalized links need to be considered carefully in this framework.

### 2.2 Stigmatization Framework

When discussing MHS, it is firstly important to conceptualize stigmatization. According to Goffman (1963), an individual becomes stigmatized because they possess a ‘discrediting’ attribute, which differentiates them from the majority and makes them a ‘discontinued’ person. This definition highlights that stigma only exists in relation to a group. In a similar manner, Thornicroft et al (2007) list three elements of stigma, namely knowledge (ignorance and misinformation), attitudes (prejudice), and behaviour (discrimination).

Stigma requires for people to be labelled. While clinical labelling of MH issues as a disease helps people understand their ‘problem’, social role theory predicts that this labelling as ‘mentally ill’ decreases and redirects responsibility for the individual’s behaviour and at
the same time triggers stereotypes and enables stigmatization (Angermeyer & Matschinger, 2003; Bizub et al., 2011 Penn et al, 1994), which may then result in negative attitudes and behaviour towards mentally ill.

Another interesting framework to consider when it comes to stigma is that proposed by Ridge and Ziebland (2012), who link depression to the ‘coming out’ framework experienced by homosexuals. This underlines the connectedness of MHCs and identity politics and the fact that the categories ‘homosexual’ and ‘mentally ill’ evolve around a stigma that is internalized, experienced and resisted in a number of ways. Furthermore, people suffering from depression or another MHC are not ‘coming out’ just once but are continuously coming out to new people in their lives (Ridge & Ziebland, 2012) – and hence have to face possible stigmatization not once but repeatedly.

2.2.1 Mental Health Stigma (MHS)

As Corrigan et al (2001) underline, stigma defines the general public's relationship with mental illness and in turn, MHS significantly undermines the quality of the lives of people, who are suffering from mental health problems. They have been found to be offered limited opportunities, as people with a mental illness are likely to not be hired, rented houses to or freely interacted with (Angermeyer & Matschinger, 2003; Corrigan et al., 2001; Corrigan et al., 2002; Penn et al., 1994; Corrigan, 2007). MHS not only attributes to relapse rates as environmental stressors increase but is also considered to be the main barrier to seeking professional help (Penn et al., 1994; Bizub et al., 2011).

MHS entails three main problems, as pointed out by Corrigan (2007). Firstly, people do not want to fall into the stigmatized category as ‘mentally ill’ and hence avoid the labelling, which prevents them from seeking help – although early and consistent MH treatment would be absolutely vital to combat MH problems (Sickel et al., 2014). Secondly, once labelled, stigma blocks ‘life goals’ for individuals as they may be considered discriminated against and/or require help in maintaining relationships, finding housing or employment (especially in cases of severe mental illness). Thirdly, stigmatization often leads to self-stigma, which means that mentally ill people internalize the negative assumptions and beliefs that their dominant environment projects onto them, leading to a decrease in self-esteem and self-efficiency (Corrigan, 2007).
2.2.2 Attitudes and Behaviors Towards People with a MHC

As outlined by Hinshaw et al. (2000), symptoms of mental illness have long been metaphorically linked to evil and lack of control as people lacked scientific or a clinical understanding of mental diseases. In 1996, Link et al. (1999) reproduced one of the first studies testing the general public’s attitudes towards mental illness in the U.S. in the 1950s, conducted by Star (1955). While Star (1955) found that the majority of respondents were fearful of described individuals with a mental illness and expressed a desire of great social distance; Link et al (1999) found that although the majority of respondents showed a better understanding of mental illnesses, being able to recognize depression and schizophrenia as well as attributing multiple causes to mental illness, the public stereotype of mentally ill people as being dangerous has in fact increased since 1955. This is significant given that other research has not only mirrored the attribution of dangerousness to mentally ill but moreover shown that it is perhaps the most damaging part of stigma as it is linked directly to the desire for social distance (Angermeyer et al., 2003; Link, 1987; Corrigan et al., 2002).

Taylor and Dear (1981) identified two further attitudes of the general public towards mental illness. Firstly, in the authoritarian view, people suffering from a mental illness are inferior and irresponsible and hence need someone to make decisions for them. The second attitude, benevolence, has rather a paternalistic character, considering affected individuals as unfortunate, child-like people, who need to be cared for (Taylor & Dear, 1981; Link et al., 1994). Analysing the link between these two attitudes and discriminatory behaviour, Corrigan et al. (2001) found that both result in the desire for social distance.

In relation to employment, Baldwin and Marcus (2006) noted that around 33% of British employers make an attempt to hire people suffering from a mental illness. They found that workers, who felt stigmatized in fact earned less than non-affected workers or workers, who suffered from a MHC but did not feel stigmatized (Baldwin & Marcus, 2006). Employers’ attitudes and behaviour towards employees with a MHC appears to also be significantly influenced by their previous experience (Brohan et al, 2010) – hence underlining that increased familiarity with mental illness impacts stigmatizing and discriminatory behaviour, which is consistent with findings regarding the general public
Employers, who have experience in employing individuals with a MHC have greater knowledge and show an adapted behaviour (are more likely to have a policy in place). Nonetheless, these employers are not likely to have a significantly more positive attitude towards mentally ill employees. The main concerns regarding the employment of people with a MHC are over symptomatology (this concern in fact increases with experience), work performance, work personality and administrative concerns. (Brohan et al, 2010). This emphasizes that individuals, who suffer from a mental illness are subject to stigmatizing attitudes not only by the general public but also by their employers.

Research on how to combat stigmatizing attitudes and behaviour has focused largely on practices such as formal statements of protest against stigmatization, which aim at appealing to the morale of the general public; education programs to increase specific knowledge; and increasing levels of familiarity through enabling individuals to be in personal contact with people suffering from a MHC. While general education programs have yielded positive results in increasing participants’ awareness and slightly decreased stigmatization, direct contact with a person has shown the most significant results in decreasing stigma (Penn et al., 1994; Holmes et al., 1999; Corrigan et al., 2002; Bizub et al., 2011). Corrigan et al. (2001) particularly found the perceived dangerousness and desired social distance from individuals with a mental illness to decrease, the higher the level of experience with mental illness. Thus, underlining that familiarity with mental illness determines the likelihood of an individual to stigmatize or not.

Overall, this research seeks to translate the existent research framework to the workplace to analyse to what extent employees, who have a higher level of familiarity with MHCs are less likely to stigmatize colleagues, who are suffering from a MHC. In relation to this, it may be useful to explore whether P&Ps, which encourage a discussion around MH and thus increase familiarity with the topic, are most considered effective in decreasing stigmatizing attitudes.

2.2.3 Disclosure vs. Concealment

MHS hinders people to openly discuss MH issues – especially in regards to the labour market (Wheat et al., 2010). In terms of employability, disclosure of a MHC can pose an
obstacle. While majority of British employers encourage employees to disclose their MHCs (Henderson et al, 2013), 1/3rd of people note that they have been dismissed or forced to resign due to a MHC; 40% note that they have been denied a job because of a history of treatment and 60% avoid applying as they expect discrimination (Wheat et al, 2010). In a recent study, the CIPD (2016) found that among employees who noted to have poor mental health, less than half (43%) disclosed their MH issues to their employer, while 29% of those that did disclose claimed to have received no support.

When looking at disclosure, Brohan et al (2012) established a model, which encompasses four different dimensions: (1) whether disclosure is voluntary or involuntary; (2) whether it is full or partial; (3) Selectiveness – whether an individual discloses their MHC widely or only to selected people; and (4) the timing of disclosure (pre-or during employment). It is useful to consider these dimensions to understand that disclosure of a MHC is a complex issue and while Brohan et al (2012) define disclosure in most cases as a choice, it is possible to argue that it is an event influenced by a number of factors and it may become inevitable once MHCs progress (Masuda, Anderson & Edmonds, 2012). The most common factors determining disclosure appears to be stigma and fear of discrimination; employment setting (perceived support by employer and colleagues); employment sector; and whether or not deviations from work routine are requested (Brohan et al, 2012).

Perhaps the most important reason for disclosure is the fact that it would allow an employee to request reasonable adjustments to the work schedule or routine and in turn essentially lowering the chances of the MHC to progress. In addition to this, disclosure of a MHC can become difficult if symptoms occur and it marks an increased psychological burden to have to hide something (Wheat et al., 2010). The advantage of concealment (if successful) would then be that it is likely easier to find a job – given that 56% of people believe they have been turned down due to disclosure of MHCs (Mental Health Foundation, 2002). Moreover, people are less likely to suffer from stigmatization and discriminatory behaviour when employed (Brohan et al, 2012; Wheat et al., 2010). Hence, it may be possible to assume that the lower the fear of stigma or discrimination within an organization, the more likely it is that employees will disclose a MHC.
2.3 Practices and Policies around Mental Health and Wellbeing

As the discussion around disclosure or concealment has underlined, employers may only be able to respond to employee needs in connection to MH and wellbeing if they are aware of the situation within their organization. As Schott (1999) emphasizes, unawareness of MHCs not only lies with the employer but also the employee. Having a supportive environment and general awareness of possible effects of work-related stress and mental health problems is essential in prevention and intervention efforts (Schott, 1999; Tennant, 2001; Iacovides et al, 2003). It is relevant to highlight that many employers use wellbeing and MH interchangeably. Hence, there are a number of common practices focusing on the general promotion of wellbeing, such as gym-memberships, aerobic exercise or free massages – which can have health benefits but may not adequately respond to work related stress or ill mental health (Shutler-Jones & Tideswell, 2011).

Supportive work environments, along with high levels of decision latitude have been found protective of MH – in turn underlining that the lack of social support can immensely increase the risks of work-related stress through high demands leading to an impairment of employees’ (mental) health (Van der Oef & Maes, 1999; Stansfeld & Candy, 2006). Acknowledging this interplay may be useful in relation to managing employees with MHCs in the workplace given they may be more likely to be impaired by high job strain and hence, the need for additional support and adjustments could be greater. In practice, this means that common practices used in relation to stress minimization or stress management, such as flexible working or regular stress audits (NICE, 2009) may not only help decrease stress but in turn also limit the risk of a MHC developing or progressing.

However, as outlined above, MH requires special consideration and with that, MHS becomes an important topic since a discussion around MH and wellbeing can only truly be encouraged when stigma is addressed. When MH is openly discussed, it is likely that the awareness of symptoms of MHCs in the workplace increases, which may not only help intervene but also prevent these issues from progressing, hence lowering the numbers of, for instance, absenteeism, presenteeism or burnouts, prevalent among employees in today’s society (Schott, 1999; Tennant, 2001). Common practices in this respect include formal policies of inclusion (making employees aware of legal entitlements) and company-wide promotion of mental wellbeing for instance in the form of workshops, which may be facilitated through internal HR or with external assistance (within the UK,
largely the NHS) (NICE, 2009; Henderson et al., 2013). In addition to this, trainings to enhance interpersonal awareness (through sharing of experiences) or communication and empathy skills have largely rendered positive results (Michie & Williams, 2003). Henderson et al. (2013) moreover found an increase in one-on-one meetings, counselling opportunities, increased numbers of flexible holiday leave – yet, importantly, no increase in actual holidays – among British employers between 2006 and 2010.

Looking specifically at burnout prevention, Awa, Plaumann and Walter (2010) distinguish between person-directed interventions (i.e. cognitive behavioural training, psychotherapy, counselling), organization-directed interventions (i.e. work process restructuring, performance appraisals) and combined interventions. While all of these efforts rendered positive results and lead to reduction and/or positive changes in risk factors, combined interventions proved to be the most successful with an 80% rate and lasting up to one year after initial intervention program (Awa et al, 2010).

As a relatively new intervention, motivational interviewing-based health coaching, which assumes evocation, autonomy and collaboration with participants, has been found to work especially well with employees who have proven to be reluctant to change (Butterworth, Linden, McClay & Leo, 2006). The advantage of individual or small-group health coaching lies in its ability to address a variety of behaviours or issues in a cost-effective manner, which Butterworth et al (2006) consider especially valuable as employee health care spending is increasingly becoming a shared burden as many employers (partly) eliminate health coverage.

**2.3.1 The Role of HR and Line Management**

As Shutler-Jones and Tideswell (2011) emphasize, employee wellbeing and health need to be embedded in the organizational culture using a proactive partnership approach and involving different stakeholders to respond to needs. Cunningham, James and Dibben (2004) moreover underline that HR systems and line management are essential parts of shaping such culture as HR typically drafts policies and line management is responsible for implementing such policies and ensuring adjustment in behaviour. It is thus HR’s role to ensure that the organization is able to respond to employee’s (psychological) needs and has adequate P&Ps in place. This also involves the training and support of line
management (Cunningham et al, 2004). Studies have shown, however, that written policies appear to not ensure proper preparation of line managers to handle situations with (mentally) ill employees – which can lead to quality HR practices becoming useless without proper organizational support for and by line management (Woodrow & Guest, 2014).

When it comes to concrete practices, line management is found to be most successful in ensuring and increasing employee (mental) wellbeing through a supportive management style, which encourages participation, delegation and constructive feedback. In addition to this, line management must be able to recognize symptoms of MHCs in order to refer an employee to occupational health if necessary (NICE, 2009). Supportive line management has moreover been strongly related to high levels of self-support and self-managing behaviour among employees suffering from a mental health problem, as it encouraged them to take their medication at work, manage symptoms of an illness as well as asking for necessary adjustments to their work design (Munir et al, 2009). Therefore, the level to which line management is perceived as supportive impacts employees’ likeliness to open up about MH issues, which in turn enables treatment and management thereof.

Yet, research shows shortcomings of management training. First, line managers in general appear to be poorly trained and inflexible when it comes to responding to ill employees’ needs – with the CIPD (2016) finding that only 10% of UK employers offer training in supporting employees with a MHC. Second, training often focuses on procedures rather than raising awareness, counselling and sharing knowledge of MHCs and work-related stress and their effects and symptoms, hence failing in raising awareness. Furthermore, there is a recognized lack of motivation as employers note that even if training is offered, line managers often fail to attend (Cunningham et al, 2004; Woodrow & Guest, 2014). Line managers are moreover under immense pressure to both, ensure employee (mental) wellbeing and deal with performance pressures, which are undermined by productivity loss due to (mental) ill-health, hence arguably hindering them from being truly empathetic (Cunningham et al, 2004).
2.4 Research Questions

The discussion of relevant literature above has outlined that MH is a complex topic and
the management of employee wellbeing and occurrence of MHCs in the workplace is a
unique challenge for employers. Three main challenges around managing MH and
wellbeing have emerged from the literature reviewed above, namely stigmatization,
encouragement of disclosure, and the role of management and HR in designing and
implementing effective P&Ps. Aiming to address these themes, this research project
brings together employers’ and employees’ experiences and perspectives around what
can be done to adequately manage MH and wellbeing in the workplace. Questions
structuring this enquiry can further be broken down into R1 and R2, outlined below.

R1 – How do employers conceptualize and address MH and wellbeing in the
workplace?

How do employers define ‘MH and Wellbeing’? Do they show stigmatizing attitudes
towards MH? How do employers estimate the burden of poor employee MH and wellbeing
on their organization? What are their P&Ps around wellbeing and MH? Do they have
specific MH policies? Do they distinguish between stress, wellbeing and MH? What is their
experience with disclosure of MHCs in the recruitment phase as well as during
employment? What kind of training do they offer to their managers? Are there differences
in relation to sector, size or nature of work?

R2 – What are employees’ experiences and perceptions around the
management of MH and wellbeing in the workplace?

What are employees’ impressions of their employers’ efforts to increase employee
wellbeing and MH? What would they consider to be the most effective P&Ps aimed at
promoting MH and wellbeing in the workplace? Do they show stigmatizing attitudes
towards MHCs and how do their levels of familiarity affect their attitude towards MH in
the workplace? Do they feel that they are able to open up about a possible MHC or engage
in general discussions around the topic and what are the factors determining their ability
to discuss MH in the workplace?
3. Methodology
This chapter will examine the methodological approach to the research project, discuss the research sample and data collection and subsequently outline ethical considerations as well as limitations to this research.

3.1 Research Philosophy and Approach
Whether consciously or unconsciously, every researcher is bound to make assumptions throughout the research process, which shape the form and outcome of their project (Burrell & Morgan, 1979; Crotty, 1998). Thus, it is vital to outline the philosophical underpinning of this research. Given the sensitive nature of the topic and complexity of mental health, this project understood that every participant had a unique view based upon personal perceptions, experiences and social conditioning. In addition, existent P&Ps were evaluated under consideration of employees’ individual experiences and perceptions. Thus, this project followed both, a critical realist and an interpretivist philosophical approach (Saunders, Lewis & Thornhill, 2016). As an ontological framework, critical realism acknowledges the complexity and plurality of any human beings’ experiences, while not considering them epistemologically superior to underlying social realities. Because critical realism is open to both, qualitative and quantitative methods of enquiry, it furthermore lends itself well to a mixed methods design (Sayer, 2000).

Since a number of research questions have been developed on the base of existent research and literature, it would be possible to classify the theory development as deductive (Saunders et al. 2016). Yet, as this project also sought to find out, what research participants’ views are and to “understand the nature of the problem” (Saunders et al., 2016; p. 147) under the assumption that new insights may arise; this project also followed an inductive approach. Hence, as it combined inductive and deductive elements and moved back and forth between the two, the research followed an abductive approach (Saunders et al., 2016; Suddaby, 2006).

3.2 Research Design
For the purpose of this project, a concurrent mixed methods approach has been chosen as this allows for the separate use of qualitative and quantitative methods within one
phase of data collection and provides a “richer and more comprehensive response to the research question” (Saunders et al., 2016, p.171). The use of two different techniques moreover allowed for a more comprehensive exploration of employers’ and employees’ perspectives (Bryman & Bell, 2015). The study combined elements of exploratory research as it set out to understand the relationship between stigmatizing attitudes, levels of support within organizational cultures, and disclosure of MHCs as well as evaluative research elements as this study looked at P&Ps and their effectiveness (Saunders et al., 2016).

Both methods were considered equally important as each of them represents one party’s views and thoughts around the topic. The data collected through each of these techniques was triangulated so that the results of each method could be compared and contrasted (Doyle, Brady and Byrne, 2009) and validity of the research increased (Saunders et al., 2016).

![Figure 1. Research Design – Mixed Methods Overview (own illustration)](image)
3.2.1 Qualitative Data – Semi-Structured Interviews

Semi-structured interviews were conducted with HR personnel and managers to gain an insight into employers’ views on the topic as well as their P&Ps. This method was chosen because semi-structured interviews can be varied and adjusted to the context of the organization and the interviewee and hence allowed for an in-depth exploration (Saunders et al., 2016) of the policies and effects as well as a possible probing for perceptions around stigma and evaluations of organizational culture in this context.

The initial question catalogue (see Appendix B) was drafted based on R1 in relation to the literature discussed in chapter 2. Each interview broadly covered three themes, namely the organizational culture in relation to MH; prevalence of MHCs in the workplace and lastly the organizations’ P&Ps and interviewees’ perceptions thereof. Each interview began with an open question about what MH and wellbeing means to the interviewee in their role within the organization.

3.2.1.1 Research Sample - Employers

Participants for the semi-structured interviews were chosen from a pool of individuals, who expressed their willingness to participate in the research by filling out an online form introducing this research project, which has been distributed through the Social Enterprise's networks. The participants were thus selected from a pool of volunteers, following a non-probability purposive sampling (Bryman & Bell, 2015). As the interviews aimed at portraying the employers’ perspective, the individuals chosen were either HR professionals or individuals in a (senior) management position as they were considered to have most inside in the organization’s P&Ps and organizational attitudes towards MH and wellbeing. Three of the interviewees did not only speak for their current organization but were considered ‘experts’ as their work involves advising organizations on issues around mental health in the workplace, hence they offered a deeper and comparative look at the management of MHCs in other organizations as well as their own. As Table 1 outlines, participants came from the private, public and third sector as well as different industries, which attributes to the data’s validity and reliability (Collis & Hussey, 2013).
3.2.2 Quantitative Data – Online Questionnaire

In order to reach a large number of employees, a self-completed online questionnaire was constructed using BOS. The 22-item-questionnaire (see Appendix D) was designed against the background of research question R2 as well as hypotheses 1-4. The questionnaire was divided into three main parts.

The first part focused on the P&Ps within respondents’ organizations as well as their perceptions thereof. A list of practices was adapted and extended from Henderson et al. (2013) to allow respondents to identify all practices offered by their employers. The second part focuses on respondents’ job and work environment. One item (“In general, how do you find your job?”) asking respondents to characterize their job on a scale between 1= ‘extremely stressful’ to 4 = ‘not at all stressful’ was adapted from Calnan et al (2004). The other four items within this section asked for respondents’ perceived levels of support from both colleagues and supervisors using a 5-point likert-scale (‘strongly agree’ to ‘strongly disagree’), and have been created on the base of the support-items of Karasek and Theorell’s (1992) Job Content Questionnaire. The third part of the questionnaire focused on respondents’ relationship with MH, asking them first to identify what they associate with the term ‘mental ill health in the workplace’ from a list of MHCs adapted and extended from Henderson et al (2013). Subsequently, four items were used
to measure attitudes towards mental illness in the workplace. These cover recommendation for a job, working alongside someone affected, concealment of mental illness at work and a person with MH issues in a leadership position. These items have been tested in a preliminary study, in which exploratory factor analysis using Varimax rotation in SPSS resulted in one dimension, thus granting validity. Lastly, the third section utilizes the level-of-contact-report (LCR) developed by Holmes et al. (1999). The LCR lists 12 situations of varying familiarity with mental illness with each of these situations given a rank score, resulting in an ordinal list from 1 to 12 from the least level of contact (1=“I have never observed a person that I was aware had a mental illness”) to the highest level (12=“I have a mental illness”). For the LCR, “mental illness” was replaced with “MHC” as this terminology was considered more appropriate for this research and to determine respondents’ levels of experience with MH. The LCR ranking has been validated and interrater reliability of rank order correlations was 0.83 (Holmes et al., 1999).

The questionnaire included three open space questions asking respondents to give their opinions on i) the effectiveness of their organization’s mental health and wellbeing practices, ii) whether or not they believe these practices distinguish between stress, mental health and general wellbeing and why, and iii) any additional thoughts on the topic. While the other items generated numerical data, the questions still focused on opinions and attitudes, hence the overall data collected with this questionnaire can be classified as ‘qualitative’ numbers (Saunders et al., 2016).

After the questionnaire was first drafted, it was sent to seven fellow UoE Business School graduate students as well as to the Social Enterprise representative as a pilot test to ensure that each item was clear and easy to understand and data collection worked properly. Upon this pilot study, small changes were made to ensure a logic structure and clarity of the questions before its distribution.

**Figure 2: Questionnaire Design Process (own illustration)**
3.2.2.1 Sample Design - Employees

To ensure that the collected data was representative and offered an insight into different employees’ attitudes and perception, the sampling followed a volunteer snowball approach (Saunders et al., 2016). As there was no selection of employees from a specific sector, organization or within a specific position, this research targeted a heterogeneous population.

3.3 Data Collection and Analysis

3.3.1 Qualitative Data

Prior to the interviews, all participants were informed of the research topic and its objectives via e-mail. Information about the confidentiality and anonymity of participation was included in the e-mail and repeated verbally before the interview. To incorporate non-verbal communication and to hence ensure a better understanding, interviews were conducted in person (Brinkman & Kvale, 2015), with the exception of P5, who agreed to have a phone interview. The interviews took place in the participants’ workplaces and all interviewees agreed for the interview to be recorded.

After the interviews, the obtained verbal data was transformed into written data through transcription, then the data was structured and coded, following a thematic analysis (Braun & Clarke, 2006) as outlined in Figure 3. The initial generation of codes followed a deductive approach as codes were identified in connection to R1. After initial themes were identified and relationships were established, the data was reviewed, following an inductive approach to identify new themes that did not relate back directly to R1. Subsequently themes were defined and an analysis report produced (see Chapter 4. Findings).

Figure 3: Process Data Analysis – Semi-Structured Interviews (own illustration) adapted from Braun & Clarke (2006)
Qualitative data obtained through the open-ended questions in the online questionnaire was analysed following an inductive thematic analysis approach.

3.3.2 Quantitative Data
The online questionnaire was distributed through the Social Enterprise’s social media channels as well as sent out to the interviewees and other individuals, who had expressed interest in the project, in an e-mail accompanying inviting recipients to distribute the survey to colleagues and friends if they felt that was something they would be confident with. The questionnaire was open and available online over a period of four weeks.

Subsequent analysis of the quantitative data obtained was done using SPSS. Two scales were identified – one measuring the levels of support within an organizational culture and the other one measuring stigmatizing attitudes around MH in the workplace. Reliability was proven for both scales (for detail see Appendix A).

Descriptive statistics were produced using frequencies to analyze occurrences of P&Ps and MHCs in the workplace as well as to understand demographic distributions.

Moreover, correlations have been applied to understand the relationship between scales measuring stigmatizing attitudes and the level of familiarity participants’ note with MHCs as well as their perceived stress at work. Independent samples T-tests have been used to establish a relationship between participants’ likelihood to discuss MH in the workplace and i) the level of support they perceive and ii) their level of familiarity with MHCs. Independent T-tests and ANOVA have also been applied to the demographic data to obtain information about whether or not there are significant differences in relation to demographic groups and their likeliness to discuss MH in the workplace as well as stigmatizing attitudes.

3.4 Ethical Considerations and Limitations
This research project was designed in line with the Economic and Social Research Council’s framework for research ethics core principles (ESRC, 2016). The topic of this research project is a highly sensitive one and it has been recognized that interviewees as well as participants of the online questionnaire were giving out personal information.
Hence, interviewees were informed about research objectives and ensured that information they shared will be treated anonymously and confidentially. The same applied to participants who filled out the online questionnaire. The questionnaire moreover included no mandatory items to ensure that all participants only answer questions they feel comfortable with – which may be considered a limitation as it impacted the findings.

Despite its promise of an in-depth understanding of a subject matter, the complexity of a mixed methods approach may be understood as another limitation of this project as the time frame and context of this dissertation only allowed for a limited exploration and analysis of the data obtained. Further limitations will be discussed in the Discussions chapter.
4. Findings

Following the methodological approach discussed in the previous chapter, the following will outline the findings of this research project. This chapter will begin with the findings from the semi-structured interviews, representing employers’ perspectives, followed by findings resulting from analysis of the online questionnaire, which represent employees’ perspectives.

4.1 Employers

“You have to take steps to look at the bigger picture... you know, is it work that is part of the problem? And can we help provide a solution?” (P3)

Areas covered in the interviews with employers served to find out, what employers’ perceptions around MH are, how this affects their organizational culture and how stigma ties into this discussion. Employers were asked about their P&Ps and the role of HR and line management. Hence, in the following, the findings within each of these areas will be outlined in Tables 2-5 among with a discussion of the main themes that arose.

4.1.1 Mental Health and Wellbeing - Employers Perceptions Around MH

Overall, all respondents appeared highly aware of MH as something that affects everyone and similar themes arose throughout the interviews – fulfillment, resilience and support being the main ones. Along with definitions of MH, Table 2 outlines the findings regarding complexity of MH, a theme picked up throughout other parts of the interviews. This section will also cover what MHCs interviewees have encountered in their workplace.
Table 2: Overview Findings: MH and Wellbeing – Employers Perceptions Around Mental Health

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-Themes</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaning of ‘MH and Wellbeing’</td>
<td>Resilience</td>
<td>● MH as ability to build up resilience and handle work demands in healthy way</td>
</tr>
<tr>
<td></td>
<td>Fulfilment</td>
<td>● MH as ability to live fulfilled lives, including happiness and enjoyment at work</td>
</tr>
<tr>
<td></td>
<td>Affects Everyone</td>
<td>● Everyone has MH and some days are better than others</td>
</tr>
<tr>
<td></td>
<td>Support Mechanisms</td>
<td>● Employers responsibility to offer good support mechanisms, be understanding and offer help → take preventative and reactive actions</td>
</tr>
<tr>
<td></td>
<td>Wholesome Approach</td>
<td>● Take all aspects of employee wellbeing into account and address issues</td>
</tr>
<tr>
<td></td>
<td>Risk Factor</td>
<td>● MH considered a risk (to performance, attendance, capability) &amp; health &amp; safety factor - importance of prevention</td>
</tr>
<tr>
<td></td>
<td>Work-Life-Balance</td>
<td>● Work impacts employee lives immensely – acknowledge interplay and create balance</td>
</tr>
<tr>
<td>Complexity of Mental Health</td>
<td>Private Lives and Professional Lives</td>
<td>● Recognition that private life as well as work life influences employees health</td>
</tr>
<tr>
<td></td>
<td>Diversity of MHCs</td>
<td>● MHCs affect people differently, even if people are suffering from the same MHC</td>
</tr>
<tr>
<td></td>
<td>MHCs as Positive</td>
<td>● MHCs as something positive → people with a MHC have unique point of view</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Having a MHC as ‘blessing’ for employer as it increases ability to be sympathetic and understanding</td>
</tr>
</tbody>
</table>

While resilience was described as a means to “feeling robust enough and well enough to deal with the demands of working in a healthy way” (P9) as well as something that can be built up, it was also connected with people’s ability to “have fulfilled lives” (P1). Fulfillment being another major that arose was moreover connected to the theme of MH affecting everyone, since everyone is entitled to fulfillment – “with or without a diagnosis” (P2).

Four interviewees spoke about the importance of having proper support mechanisms “not just those who are suffering from mental health issues [...] but for everybody to avoid getting to that point where they then suffer from that kind of thing.” (P8). Thus, recognizing their role within their organization to not only support employees with a MHC but also take preventative measures.
Interconnectedness between general wellbeing and MH was also recognized, hence portraying a more wholesome approach. In addition to this, the interplay between employees' private and personal lives was mentioned in relation to "finding the right work-life balance" in order to have "the best capability and mindset" (P10) within the organization.

The complexity of MH was largely recognized as many interviewees pointed out that MHCs affect different people in different ways and hence, each case needs to be handled individually. Interviewees highlighted that different factors attribute to someone’s MH, as it “does not happen in a vacuum” (P4).

A new theme that arose was consideration of MHCs as something positive, as employees with a MHC have a unique viewpoint. Having suffered from a MHC, one employer describes how it enabled them to console and support employees better. Similarly, one respondent describes how “we’ve all learned from one person’s journey and [...] we’re better at helping the general public now” (P3).

**4.1.1.1 MHCs Encountered in the Workplace**

Interviewees most commonly noted to have encountered ‘stress’. While seven participants said stress, two of them highlighted that it is not a MHC in itself but a cause thereof. Depression was encountered by five interviewees; anxiety by three and three people mentioned exhaustion/burnout. Two interviewees also noted having to deal with anger and two other interviewees pointed to the intersection of physical conditions and their MH toll on employees. Schizophrenia, eating disorder, bipolar disorder, trauma and substance abuse were each named once by different employees. While interviewees noted to have encountered around two MHCs on average, one interviewee has encountered eight of the above-mentioned MHCs. Only one interviewee noted to not have had encountered any MHCs among employees in their workplace.
4.1.2 Organizational Culture and Stigma
When asked to describe their own organization culture in relation to MH and wellbeing, most interviewees noted a challenge of dealing with organizational pressures as well ensuring inclusion and having good support mechanisms. When it comes to stigmatizing attitudes within organizations, perceptions varied a little as many described there to be no stigma while others recognized it to exist, yet would overall describe their organizational culture as open in relation to MH.
<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-Themes</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organizational Culture</strong></td>
<td>Stressful</td>
<td>• Stressful environment as well as stress brought about by over-commitment of employees (values-driven work)</td>
</tr>
<tr>
<td></td>
<td>Workload, Demands &amp; Pressures</td>
<td>• Heavy workloads, great demands and high pressures on employees</td>
</tr>
<tr>
<td></td>
<td>Diversity and Inclusion</td>
<td>• Include people with MHCs, recognition that everyone is different and also MHCs are different for everyone</td>
</tr>
<tr>
<td></td>
<td>Awareness and Understanding</td>
<td>• Foster Team-Work</td>
</tr>
<tr>
<td></td>
<td>Support</td>
<td>• Involvement → No ‘us’ vs. ‘them’</td>
</tr>
<tr>
<td></td>
<td>Openness</td>
<td>• Awareness that work environment may interfere with employees MH in a number of ways → support employees so that they can perform well</td>
</tr>
<tr>
<td></td>
<td>Communication</td>
<td>• Importance of openness and honesty → Communication as key to inclusive and supportive culture</td>
</tr>
<tr>
<td></td>
<td>Importance of Relationships</td>
<td>• Problem with leadership - recognition that openness about MHCs in management increases acceptance</td>
</tr>
<tr>
<td></td>
<td>Improvements</td>
<td>• Relationships with and among employees more important than supportive structures or process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Culture improving – discussion of MH becoming more acceptable and more focus put on MHCs</td>
</tr>
<tr>
<td><strong>Stigmatizing Attitudes</strong></td>
<td></td>
<td>• Despite high levels of awareness, stigmatizing attitudes to exist in most organizations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• MHC among managers seen as weakness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stigma noted to be lower, the more employees openly discussed their MHCs in the workplace</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Overall high levels of sympathy and understanding for employees suffering from MHCs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Noted negative attitudes among employees when it comes to high pressures and stress and increased workloads on account of absence of affected employees</td>
</tr>
</tbody>
</table>

Table 3: Overview Findings: Organizational Culture and Stigmatizing Attitudes

Culture was often described in relation to stress and also over-commitment as for instance “some of our employees will put the welfare of the people we support before their own wellbeing” (P2). Such stress, workloads and demands were also linked to support,
underlining that despite high levels of awareness and sympathy, managers are often pulled in different directions and “we don’t always get it right” (P4). Yet, there was also a lot of emphasis on involving employees and supporting them in order to enable them to “work hard and go the extra mile” (P8).

Working in a high-pressure environment was also described in relation to employing employees with a MHC by several interviewees, who emphasized the importance of communication to support these employees as best as possible: “I need to know if they’re not having a good day and I can try and re-organize the day’s work around that” (P3).

Interestingly, one interviewee described their organizational culture as supportive and open but underlined “my experience with Scottish culture is that [MH] is hidden” (P3). This view was shared by one of the experts, who noted that while there are some examples of great organizational commitment, “there is a problem with leadership” as “people are really not feeling supported most of the time” (P5). Lack of managerial commitment is also to be visible in the fact that “very rarely senior managers come along” to the interviewees MH awareness courses targeting managers. Speaking from their experience of working with different employers, another expert remarks that regardless of support processes and structures “what it comes down to are relationships people have in their work environment” (P9) and that MH and wellbeing tends to overall be better in smaller organizations due to higher levels of autonomy and role clarity.

Employers who perceived no stigma to be attached to MH often said this was the case “because so many people are so open about their own mental health issues” (P2), underlining that openness and discussion of the topic decreased stigma. The issue appeared to be more complex, however as within some of the same organizations, tensions within the workforce were mentioned in relation to employees who were frustrated when colleagues went off sick and they had to pick up the work and in those cases, negative comments or jokes may have been made.

Recollecting previous work in the private sector, one interviewee notes, “there was more fear there” (P2). In support of that, another interviewee from within the private notes that people still do not feel comfortable opening up, citing problems getting people to sign up
for a disability network and in turn disclosing a disability or MHC, while overall emphasizing that culture is improving in this respect.

### 4.1.3 Experiences with Disclosure

One of the main themes that arose from discussing experiences with disclosure of MHCs with employers was (fear of) stigma and discrimination, despite the fact that the majority of employers encouraged disclosure as a means to find a solution and manage their employees better.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-Themes</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience with Disclosure</td>
<td>Time of Disclosure (Pre- or During Employment)</td>
<td>• Only few cases of disclosure prior to employment as people tend to test out environment before deciding to open up&lt;br&gt; • Disclosure can never be ‘forced’ yet in cases, it can become inevitable when symptoms interfere with capability to work&lt;br&gt; • Disclosure recognized as ‘big issue’&lt;br&gt; • Awareness that discrimination exists and understanding that this is the reason people choose not to disclose MHCs&lt;br&gt; • Inability to offer support/help or manage situation without knowledge of MH situation → Communication as key to enable understanding and make reasonable adjustments&lt;br&gt; • Learning from experience → organization notably becoming more aware after disclosure took place&lt;br&gt; • Employees must be empowered to share by signaling openness and acceptance&lt;br&gt; • Trust, openness and supportive management structures as main factors increasing likelihood of disclosure while fear of discrimination, lack of trust and (internalized) stigma most likely to hinder it&lt;br&gt; • Most common work adjustments include: change in work pattern/time, changing teams, flexible leave, absence and return to work management, continuous communication&lt;br&gt; • People tend to wait until it gets too bad</td>
</tr>
<tr>
<td></td>
<td>Fear of Discrimination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discussion Enables Solution</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Factors Determining Likelihood of Disclosure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Work Adjustments</td>
<td></td>
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</tbody>
</table>

*Table 4: Overview Findings: Experience with Disclosure*

The interviewees who have had employees disclose a MHC noted this to have happened largely during employment, not prior to it. Employers noted that questions around MH
are not part of their recruitment strategy, and if disclosure appeared prior to employment, this was voluntary.

Underlining the issue around stigma and discrimination, one expert spoke about their experience of working with people with MHCs, who were asked about gaps within a CV, which were the result of a mental illness, and upon disclosure were denied a job. Hence, people “quite often wait; they suss the place out first before they feel that they know if they would get a bad or good reaction when they’re talking openly about their mental health” (P1).

Another major theme that was mentioned by several interviewees was the perception that while it is their employees’ right to disclose or choose not to, employers “can’t help and can’t be part of the solution unless I have the full information” (P3). In addition to this, the aspect of disclosure becoming inevitable was picked up by recollections where employees’ MHCs have interfered with their work.

Employers explained high disclosure rates with high levels of support and particularly managers being open about their own MHCs, thus underlining the importance of openness when it comes to the likelihood of disclosure. One of the expert underlined this by stating that best practice organizations show a supportive management structure and visible examples to signal employees how things are enacted within their organizations.

4.1.4 Organizational Practices and Policies
In order to find out, what kind of support mechanisms employers have in place, interviewees were asked about their company’s P&Ps around MH and wellbeing.

Only two interviewees noted that their organization has a specific MH and wellbeing policy in place, while many participants noted MH to be covered under health and safety, sickness and absence policies or a stress management policy. Most interviewees said their organizational policies to have largely been drafted top-down with involvement of HR and line management. In addition to this, a responsible business department, the employment law team, and the trade union have been named. Some participants also noted their organizations’ policies to fall under a larger national policy framework, and hence
“implementation true to intention cannot always be ensured” (P9). Overall, policies are moreover frequently reviewed and updated.

Figure 4 lists the organizational practices around MH and wellbeing mentioned by participants. This includes practices that were mentioned when adjustments for employees with a MHC were discussed.

![Organizational Practices Mentioned](image)

**Figure 4: Overview: Organizational Practices Mentioned by Employers**

When it comes to the effectiveness of P&Ps, most interviewees said they had employee feedback mechanisms in place with some listing employee involvement as a priority. Yet, while the opportunity for feedback may be there, one of the experts highlighted that trust is often a central issue and employees may not be as honest when they “question the anonymity of feedback loops or services offered within organizations” (P5).

Interviewees noted to receive feedback both formally (in the form of questionnaires for instance) and informally (many interviewees emphasized their open-door policy).
While the majority of respondents estimated their practices to be very effective, one respondent underlined that “they need to be updated and we could certainly do better”, adding later “you know, you have your electricity test done every year, let’s do something about mental health and wellbeing every year” (P3).

4.1.4.1 Distinction between General Wellbeing, MH and Stress
Interviewees were also asked how their organizations distinguish between general wellbeing, mental health and stress. Responses were mixed from distinguishing them clearly to understanding them as intertwined.

Those who underlined that they distinguish between these areas mostly said so because they understand that people need to be supported in different ways and that for instance, MH “is not always as straight forward as physical health problems” (P8).

In contrast to this, some employers noted to not distinguish, emphasizing they deal with all problems and don’t want to “put [them] in a box” (P6) or stressing the interconnectedness between the areas.
### 4.1.5 Role of HR and Line Management

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-Theme</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Role of HR</strong></td>
<td>Knowledge of Resources</td>
<td>• Involvement in formulation of practices and policies</td>
</tr>
<tr>
<td></td>
<td>Formulation of Practices and Policies and Review</td>
<td>• Offering support and knowing resources they can refer employees to → reference to medical professionals</td>
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<td></td>
<td>Support for Employees and Management</td>
<td>• Offer advice and training to management</td>
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<tr>
<td></td>
<td>Progress Monitoring</td>
<td>• Monitor progress of ‘sick’ employees → Supervision of (long-term) sickness absence, return to work as well as exit management</td>
</tr>
<tr>
<td><strong>Role of Management</strong></td>
<td>Role-Modelling</td>
<td>• ‘Role-Modelling’ Openness about MH</td>
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<td></td>
<td>Support</td>
<td>• Management support vital for acceptance of MHCs in the workplace → organizational commitment needs to be visible</td>
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<td></td>
<td>Management Training</td>
<td>• Good management to be proactive → seeing changes in employees and hence enabling early intervention to poor MH</td>
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<td></td>
<td></td>
<td>• ‘Learning by Doing’ - Managers learn how to deal with employees suffering from a MHC and are better equipped to handle next situation</td>
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<td></td>
<td></td>
<td>• Training offered largely not mandatory</td>
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<td></td>
<td></td>
<td>• Training covers: awareness (ability to spot changes and warning signs), seminars on legal issues, focus on own MH</td>
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<tr>
<td></td>
<td></td>
<td>• Specific Courses: Mental Health First Aid Training, 2-Day-Training certifying Managers to become trainers in their organization</td>
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</tbody>
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*Table 5: Overview Findings: Role of HR and Line Management*

The main themes that arose in relation to what HR’s role is in fostering employee wellbeing and MH were that they knew the resources to refer employees to, formulated and reviewed P&Ps and supported employees, for instance monitoring sickness absence and return-to-work processes. As one central theme was also training of management, HR was often mentioned as offering advice and coaching as to how to deal with employees with a MHC.
One interviewee interestingly pointed to the limitations within supporting employees, underlining that “at the end of the day, we’re HR but we’re not medical professionals and we don’t have all the answers for people, unfortunately” – hence, while acknowledging employers’ responsibility to care for their employees’ (mental) wellbeing, in the case of a MHC, the referral to other resources may be the most supportive initiative.

While most participants recognized management training as an important factor, those interviewees who said their organization is offering formal training for line managers said it was not mandatory. Apart from HR coaching, employers mentioned to offer awareness training, and specifically the *MH First Aid Course*. Four interviewees noted not to offer any training, yet in part this was due to the small size of their organization. Two interviewees moreover took a note as this was something they said they “need to look into”.

When it comes to the role of management, a lot of it ties in with the discussion around organizational culture, disclosure and stigma as most interviewees remarked the importance of (top-level) management support and in a sense ‘role-modeling’ openness by showing that it is acceptable within organizations to discuss MH openly. In contrast, one of the experts discussed that many managers feel the stigma of a MHC being perceived as a weakness in their position.

While some interviewees evaluated experience more positively than training, many agreed on the importance of having an aware line manager, who is able to recognize changes in someone’s behavior in order to manage a possible MHC proactively and not reactively also came up.

**4.2 Employees**

The following outlines employees’ impressions around their employers’ efforts to increase employee wellbeing and MH by looking at how employees evaluate organizational P&Ps in order to also understand what is perceived most effective.

Subsequently, findings regarding respondents’ perceptions around their organizational culture, stigmatizing attitudes and experience with MHCs will be outlined in order to
understand how these are interrelated as well as contrast employees’ perceptions with that of employers. Lastly, the discussion around disclosure will be analysed from the employees’ side to gain an understanding over what the main factors are in determining the likelihood of employees discussing a MHC in the workplace.

### 4.2.1 Preliminary Findings – Demographic Distribution

The questionnaire generated a total of 106 responses. It is important to note that no items were mandatory, hence not all data adds up to 106 responses. See below the demographic distribution.

**Figure 5: Gender Distribution**

**Figure 6: Age Distribution**

**Figure 7: Sector Distribution**

**Figure 8: Size of Organization**

*Figure 5-8: Preliminary Findings: Demographic Distribution of Respondents*
Independent Samples T-Tests have been applied to determine whether gender has made a difference in any of the responses discussed below, yet no significant relationship has been found.

### 4.2.2 Practices and Policies and Evaluation Thereof

![Organizational Policies and Practices](image)

**Figure 8: Overview over Selected Organizational Practices and Policies in Percentages. Based on Responses to Q1.**

Employees most commonly listed flexible working hours as a practice within their organizations, followed by one-to-one formal reviews and flexible holiday policy. Practices specifically targeting MH issues were selected more rarely, with only 25,5% noting that their organization offers ‘EAP/Helpline’ and 42,5% ticking ‘access to counseling’. For the ‘Others’ box, ‘Mental Health First Aid Training’ was specified.

Reflecting the high percentage visible in Fig. 8, a total of 40 respondents noted that they found flexible working arrangements (flexible working hours and working from home) particularly helpful as it enabled them to “fit my work and home life together”; cater to
"care responsibilities" and overall "helps to maintain a balance and reduce stress". One respondent noted it has helped "to manage my health condition".

15 respondents moreover found one-on-one review meetings to be very useful as they "are most helpful in drawing out issues and finding solutions", yet only "as long as there is a culture of supporting people living with mental health issues". Overall, the manager’s approachability has been noted several times and one respondent wrote: "having an understanding manager has helped the most." In contrast, one respondent noted that "meetings depend on the personality of manager and could be even threatening rather than supportive". Hence, underlining that while regular one-on-one review meetings offer a chance to "allow conversations to deal with issues as they arise rather than building up" – noted to include issues in work and private lives – their quality appears to depend both on the organizational culture and the manager.

In addition, four respondents stated to have taken up all of the practices and emphasize their overall added value to a healthy working environment while EAP/Helplines and counseling were evaluated positively as they offered (employer) support, with one respondent noting it was "hard to discover it was available". Gym memberships and Pilates classes have been listed four times as helpful with stress management.

66,3% of respondents believed that P&Ps did not adequately distinguish between stress; MH; and wellbeing, whereas 33,7% thought they do. Many of those, who thought they did, attributed this to their employers’ openness and that different issues were addressed differently.

Some respondents also noted that the three should not be distinguished or treated “separate” but "are all under one umbrella": “Everyone needs to focus on their mental health which includes stress and impacts upon our general wellbeing”.

As the majority said their organizations did not adequately distinguish, one of the main reasons listed was lack of awareness or understanding of MH with respondents writing "I think MH is not well enough understood as a whole and it’s difficult for individuals to know
how to tackle it” or “not enough emphasis has been placed on supporting MH. Still very much under the radar”.

Three respondents use the term “to tick a box”, questioning their organization’s sincerity when it comes to these practices: “There is little evidence of pro-active initiatives towards MH”.

Four respondents addressed stigma, one writing “there is stigma attached to asking about MH and it is much easier to put it down to stress”. One respondent also writes “Far more sympathy given for cancer (yes I have had both).” Another respondent describes a similar experience, writing about her cancer treatment, which “was actually a benefit in disguise as it was my mental illness which was the worst” while also noting they did not think they would have been promoted had they disclosed their MHC.

### 4.2.3 Organizational Culture

![Stress Chart](chart.png)

*Figure 9: Perceived Levels of Stress. Based on Responses to Q4.*

Only 9% of respondents noted their job to be extremely stressful while the majority (55%) it as ‘somewhat stressful’.

Overall, perceived organizational support was relatively high as the scale measuring supportive culture (5 = high, 1 = low) showed an overall mean of 3.6.
Relating levels of stress to perceived organizational support, a modest negative correlation has been found \( (r = -0.225, p = 0.023) \). Hence, respondents who noted their jobs to be less stressful were more likely to describe their organizational culture as supportive.

Significant differences have been found in relation to perceived support and whether or not respondents’ would feel comfortable speaking up about MHCs within their current organization \( (t = 4.310, p = 0.000) \). This result implies that respondents who perceive their organization and colleagues to be more supportive are also more likely to feel comfortable discussing MH in the workplace. Those respondents noting they would feel comfortable on average scored higher when it comes to perceived support \( (M = 3.77, SD = 0.805) \).

### 4.2.4 Awareness of and Familiarity with MHCs

In terms of frequency, anxiety was selected most commonly \( (90.6\%) \), followed by depression \( (88.7\%) \) and stress \( (86.8\%) \). See Fig. 8 below for the total distribution of MHCs listed. Additional MHCs named by those participants who checked other were bullying and insomnia as well as two respondents noting ‘all of the above’.

Respondents on average checked 5.5 of the 11 possible MHCs (see Appendix A for detail).

![Figure 10 – MHCs Associated with the Term ‘Mental Ill Health in the Workplace’ in Percentages. Based on Responses to Q9.](image.png)
21 respondents scored a 12 on the LCR, hence stating they have a MHC, while only 1 person scored a 1, hence demonstrating no familiarity with MHC. The LCR mean was 7.9 (SD = 2.89), indicating overall high familiarity of respondents with MHCs.

While no significant differences have been found in terms of participants’ levels of familiarity and how it affects their likelihood to discuss MH in the workplace, the mean of familiarity for people who noted they did not feel comfortable speaking up about a MHC was slightly higher (M = 8.38, SD = 2.77) than that of participants who said they would feel comfortable speaking up (M = 7.83, SD = 2.93).

### 4.2.5 Stigmatizing Attitudes

The majority of respondents (56%) agreed to recommend someone with a MHC for a job. Moreover, 43.1% strongly agreed and 48% agreed to the statement that they would not mind working with someone with a MHC. 32% of respondents strongly disagreed and 41.7% disagreed with the statement that MHCs should be concealed at work. When it comes to trusting a person with a MHC in a leadership position, the majority of respondents either agreed (49%) or strongly agreed (22%) with the statement.

A strong tendency to a significant correlation between the level of familiarity and stigmatizing attitudes has been found (p = .052) with a negative correlation of $r = - .192$. Hence, the more familiar respondents were with MHCs, the lower they scored on items measuring stigmatizing attitudes.

Overall, respondents showed low levels of stigmatizing attitudes since the scale measuring stigmatizing attitudes around MH in the workplace showed a mean of 1.96 (SD = .6).
4.2.6 Disclosure & Factors Determining Likelihood of Discussing MH in the Workplace

33 respondents (34%) noted that they have disclosed a MHC, with only 6 people having disclosed prior to and 27 during employment.

82% (84) of respondents said that they would feel comfortable speaking up about a MHC within their current organization, while 18% said they would not. When testing for whether there is a significant relationship between the sectors respondents worked in and their likeliness to speak up about a MHC, a significant relationship has been found ($\chi^2 = 13.19, p = .004$). The results showed that participants from private and third sector were more likely to speak up about a possible MHC than respondents from the public sector.

Respondents who said they felt comfortable speaking up about a MHC within their organizations most commonly explained that this was due to having an open and supportive organization culture, a “safe environment”, that enables them to share and discuss issues, with approachability of management being mentioned several times.

Another major reason listed by people who said they would feel comfortable speaking up is to increase awareness as a way to ensure improvements (“If we ignore it, it gets worse”) and dispel stigma around MH. “To banish myths and stereotypical attitudes […] and to ensure anyone with poor mental health at any given time can still access mainstream and get the help and support they need”, writes one respondent while another notes “The more people know, the better they understand. Ignorance is a barrier”. One respondent writes “It affects so many people and might be a relief for those suffering in silence to see that they are normal”, hence also underlining that MH affect a lot of people, which was an argument picked up by many other respondents (“Millions of others suffer and no one should feel like they have to suffer alone”).

The minority that answered “No” largely attributed this to stigma and fear of discrimination. One respondent explains: “would get laughed at by co-workers”, another one: “would be seen as sign of weakness, unreliability and ‘typical female’ emotional”. One respondent claims “if I had depression I feel that it would be used against me”. Similarly, others state that while they themselves would be supportive, they would not be
comfortable opening up as it may cost them career opportunities – albeit “this would be done with good intentions”.

4.3 Summary of Key Findings
The section above has outlined the main findings regarding employers’ and employees’ perspectives around MH and wellbeing in the workplace. Interviewees representing employers showed overall high levels of awareness and understanding of MH as a complex matter and described their organizational cultures as supportive. No interviewee showed signs of stigmatizing attitudes and despite almost none having a formal MH and wellbeing policy in place; there are P&Ps covering the area. While the role of HR was portrayed largely a supportive one, line management appeared to be more complex with almost all interviewees recognizing the importance of proper training yet no one marking it to be mandatory.

Moreover, the most notable findings around employees’ perspectives have been that they perceive flexible working arrangements along with one-on-one meetings to be most effective as well as valuing the importance of openness and support within organizations. Perceived support was overall high, while levels of stress remained moderate. While respondents showed average levels of awareness of MHCs in the workplace, levels of familiarity appeared to be rather high. Respondents showed low levels of stigmatizing attitudes; yet the minority who claimed to not feel comfortable discussing MH in the workplace commonly highlighted stigma as a reason. In line of this, a supportive and open environment was most commonly listed to enable discussion of MH in the workplace.
5. Discussion
In this section, the findings for both employees and employers will be compared and contrasted as well as set in the context of the literature discussed in Chapter 2. The discussion will begin with a comparative outline of levels of awareness among employees as well as employers when it comes to MHCs in the workplace. Then, organizational culture in relation to MH will be discussed considering perceived support. Moreover, the role of stigma will be analyzed and experiences around disclosure will be assessed. Subsequently, impressions from both employers and employees will be examined in relation to organizational P&Ps and their effectiveness. Furthermore, the importance of the managerial role along with training will be discussed. Finally, limitations and further research opportunities will be outlined.

5.1 MH and the Workplace
Research has shown that UK employers are increasingly focusing on MH in the workplace as they realize not being able to adequately manage employees with MHCs not only costs them money but potentially talent (Henderson et al., 2013). As the majority of UK employers moreover noted to require more support in the area (Brohan et al., 2010), this study sought to find out how employers define MH and wellbeing and how aware they are of the impact of poor employee MH.

In contrast to findings by Henderson et al (2013), in which 1/3rd of UK employers noted that none of their employees suffered from a MHC, only one of the interviewees noted to never have encountered a MHC in the workplace, while the majority noted to employ people with a MHC. Their awareness of this was also mirrored in many respondents’ definitions of ‘MH and wellbeing’ as they spoke about the importance of building up resilience, living fulfilled lives “with or without a diagnosis” (P2) and largely recognizing that everyone’s MH can be poor at times.

While depression was the most commonly encountered MHC – which is consistent with research findings by Wheat et al. (2010) –, it is important to highlight that nearly 60% of respondents named ‘stress’ as an encountered MHC. While two respondents did point out that stress is not a condition but a cause; this high number underlines that stress tends to be thought of first in relation to MH. Interestingly, substance abuse, the third most
common MHC (Wheat et al, 2010), was only mentioned once among with other common MHCs and more severe ones like Schizophrenia. This may be explained - as one respondent of the online survey highlighted – because it may be easier to address stress than MH because of stigma. Considering that stress has been covered more widely and the terminology is often used interchangeably (Shutler-Jones & Tideswell, 2011), it is also be possible to assume that employers are more likely to recognize and openly discuss stress than MHCs.

Yet, these findings do not necessarily point to a lack of awareness considering that stress is strongly connected to the development of MHCs (Tennant, 2001) and job stressors may perhaps be more controllable from the employers’ perspective. Moreover, most interviewees recognized MH as a complex matter that is affected by a number of different factors, most notably perhaps being the interplay between the private and professional sphere. As highlighted by Clark et al. (2012), both work and non-work stressors impact MHCs independently – a finding that was mirrored in interviewees’ responses not only through the recognition of employees having pressures and responsibilities that interfere with their work-life but also in the majority of interviewees understanding it as the employers’ responsibility to create support mechanisms that comprise these factors.

Support mechanisms in relation to MH are especially important considering that both stress and common MHCs are rooted in workload pressures and lack of support (HSE, 2015). Hence, the majority of interviewees’ emphasis on wanting to support employees as well as their recognition of MH as complex, not only in relation to the interplay between private and work life but also the fact that MHCs look different for everybody, can be considered a reflection of Henderson et al.’s (2013) findings of UK employers recognizing the need to focus on MH.

Since existent literature has found a supportive environment to be connected to increased awareness and in effect protective of MH (Schott, 1999; Iacovides et al., 2003; Stansfeld & Candy, 2006), it is also important to consider perceptions of organizational culture. Interviewees commonly talked about work pressures and stress in relation to support, indirectly underlining a balance of the two. Support of this was found when looking at employee responses as those who perceived their organizational culture as supportive on
average also described their job as less stressful. Overall, employees’ perceptions of organizational support was relatively high on average, with some specifically pointing out that having a supportive and understanding management and culture is vital in relation to good MH and wellbeing - hence, confirming existent research’s link between support and wellbeing.

In conclusion, the findings underline that employers participating in this study appear to be aware of employee MH as an important factor as well as recognizing their responsibility regarding support mechanisms. It appears that employees participating in this study not only perceived high levels of support but both employers and employees moreover recognized it as a key factor ensuring good employee MH.

5.2 Mental Health Stigma

As discussed in Chapter 2, MHS significantly impacts people’s quality of life as they experience exclusion as the general public is showing a desire for social distance as most commonly found discriminatory behavior (Corrigan et al., 2001; Angermeyer & Matschinger, 2003). In relation to the workplace, research has found that those employers who hire employees with MHCs, while showing greater awareness through experience, still largely express concerns over symptomatology, performance and work personality (Brohan et al., 2010).

Yet, within this study, only one of the interviewees mentioned concerns about performance and capability while with the majority, the focus lay on treating MHCs as something that occurs and needs to be dealt with in a supportive manner. Thus, overall stigmatizing attitudes on sides of managers and HR appeared to be very low, with several mentions of showing employees that having a MHC is normal on accounts of openness about personal experiences. When interviewees described their workplaces to have low stigma, they explained this through openness and one respondent emphasizing that their small team has learned “from one person’s journey” (P3). These findings appear consistent with research finding familiarity with MHCs to be the key determinant in decreasing MHS (Corrigan et al., 2002; Bizub et al., 2011). Similarly to Brohan et al’s (2010) findings, awareness appeared to increase immensely with experience yet contrary to their findings, instead of concerns over capability and performance, a stronger desire to
support employees proactively was expressed – which in turn emphasized part of the responsibility to lie with the employer.

The positive link between familiarity and decreased stigma was also found in employees’ responses, hence supporting existent research findings. It is important to point out that overall, employees noted to be very accepting of colleagues or even a leader with a MHC in the workplace. While these findings rely on self-reporting, these results nevertheless point to very low levels of MHS, which perhaps is most evident in the fact that the vast majority of 84% of respondents claimed they would feel comfortable speaking up about a MHC in their workplace (which will be discussed in more detail in the next section).

However, employers as well as experts interviewed mentioned having different experiences in other organizations and underlined that when it comes to support of MH, there appears to be a lack of leadership and organizational commitment. Although MHS has been recognized by most interviewees, only one respondent (from the private sector) openly acknowledged stigma hindering discussion of MH in their workplace, while emphasizing that focus on MH is increasing. Other interviewees highlighted having an inclusive and supportive culture despite recollecting tensions among employees on account of MH related sickness absences, which underlines the complexity of MHS as it appeared MHCs were considered acceptable in the workplace unless they interfered with colleague’s work loads.

To conclude, the association between familiarity with MHCs and increased acceptance as well as decreased MHS, as noted in existent research, has been confirmed in this study. Moreover, while both employers and employees participating in this research project appeared to have little stigma attached to MH, they did recognize it to exist.

5.2.1 Discussion of MH and Disclosure of MHCs
As the discussion around MHS in Chapter 2 has outlined, people with a MHC not only experience discrimination but in turn, also often choose to conceal a MHC in the workplace with a recent study by the CIPD (2016) confirming that less than half of UK employees (43%) who reported having poor MH disclosed this information to their employers.
Considering Brohan et al.’s (2012) model of disclosure, findings of this research show that the majority of employers experienced voluntary, full disclosure during employment. While it is of course difficult to generalize these findings considering that interviewees were also only able to refer to the cases they were aware of and disclosure of MHCs to colleagues may be more common than noticed by (HR) managers. The fact that disclosure took place more commonly during employment is in accord with other research findings by Wheat et al (2011) and Brohan et al (2012), which found that discriminatory tendencies to be lower in relation to disclosure during employment to see how their employer would react to disclosure. Employees’ responses were highly consistent with these perceptions as 82% of respondents who have disclosed a MHC, did so during employment.

Similarly to findings by Henderson et al (2013), the majority of interviewed employers encouraged disclosure while recognizing its employees right to choose not to. The main argument for disclosure on the side of interviewees has been their inability to adequately support employees. This view is very much consistent with existent literature, which stresses the increased psychological burden of concealing a MHC (Wheat et al., 2010). Looking at the employees’ perspective - as mentioned above – interestingly, the majority of respondents (82%) noted that they would feel comfortable discussing MH in the workplace, which can be considered a positive result in connection to employers’ desire for disclosure in order to address issues in a timely manner. This result stands in contrast to the CIPD’s (2016) finding of disclosure comfort being at 42%. This, however, may be explained considering that some respondents replied hypothetically and moreover because respondents were potentially more aware of MH than the general public.

Not only did statistical findings show that those employees who noted to perceive high levels of organizational support were also more likely to discuss MH in the workplace, but this was also mirrored in employees’ responses who attributed their likeliness to discuss MH in the workplace to having an open and supportive environment as well as approachable management. Along with the second most common theme attributed to discussion of MH was to foster improvements and dispel stigma, these factors were in line with findings by Brohan et al. (2012) and may in turn contribute to the explanation of why
employees wait to disclose a MHC, as they are unable to determine whether or not the organization would be supportive prior to their employment.

The most common factor determining disclosure according to Brohan et al (2012) was fear of discrimination and stigma, which was also found as a main reason listed by participating employees, who noted they would not feel comfortable discussing MH in their workplace. Albeit the minority of respondents, the reasons employees gave were not only overall harsh but resembled one of the expert’s perception of MHCs being interpreted as a weakness by many.

When it comes to sector differences within the UK, research has found the private sector to be less supportive in relation to MH than the public or third sector (CIPD, 2016), which is consistent with findings regarding interviewees’ perceptions. Yet, surprisingly, when looking at employees’ responses, results showed that employees from the private and third sector were more likely to say they feel comfortable discussing MH in their workplace than in the public sector. Although it is vital to acknowledge this contrast, the result may in part be explained due to the high proportion of respondents from the third sector.

In conclusion, it has been found that both employers and employees participating in this study appeared to have a positive attitude towards discussing MH in the workplace. Despite the majority of respondents noting they would feel comfortable discussing a MHC in their workplace, MHS still appeared the key determinant in hindering such discussion – thus underlining the importance of openness and transparency around the topic in order to encourage a discussion of MH and disclosure.

5.3 Practices and Policies
Research has claimed that many employers use the terms ‘stress’, ‘wellbeing’ and ‘mental health’ interchangeably and in turn fail to adequately address employee health issues (Shutler-Jones & Tideswell, 2011). While some interviewees were highly aware of distinguishing at least between physical and mental wellbeing, either explicitly in their policies or in the way they support their employees, some employers underlined not to distinguish in order to deal with every problem equally or because they believed them to
be interconnected either way. While few employees supported the opinion of everything being interconnected, the majority believed that their employers did not distinguish adequately with many attributing this to a lack of awareness and understanding of MH. Thus, these results indicate employers should emphasize the treatment of these issues as separate entities, as is suggested by Shutler-Jones & Tideswell (2011).

These findings can be related to Henderson et al’s (2013) findings, which not only suggested that UK employers require more support in this area but moreover that 80% of them did not have a formal policy on MH. This result was in fact matched exactly by this study as only 2 out of 10 employers noted to have a specific MH policy. Yet, this low number of specific policies may be explained – as many interviewees emphasized – with the embeddedness of MH in health and safety or absence policies and in turn related back to the problem of lumping together physical and mental health as well as stress.

When it comes to what employees perceived to be the most effective practices, these were: flexible working arrangements, including working from home and flexible holiday leave. It was specifically underlined that they contribute to stress reduction and enable management of health conditions. Hence, while literature has largely pointed to these practices as most effective in relation to stress minimization (NICE, 2009), these findings may also support the claim that they are effective not only in protecting good MH but also facilitate coping with a MHC.

Interestingly, flexible working was only mentioned two times by interviewees while several spoke of adjustment of work regarding management of employees with a MHC. Most interviewees noted to offer EAP/Helplines, counseling or referral to occupational health when asked about specific P&Ps around MH and wellbeing. What is important to consider is that when it comes to EAP and counseling, employees, who have good MH may be less likely to be aware of their existence as well as unable to evaluate their effectiveness. Hence, this may explain the contrast between employees emphasizing flexible working as it is something that is beneficial to all employees, while interviewees specifically noted to receive good feedback for EAP or counseling by employees who have been in need of these practices specifically targeting poor MH.
Numbers of general MH awareness trainings or initiatives were very low both among employees and employers despite literature underlining it as a common practice to promote inclusion (NICE, 2009; Henderson et al, 2013). Yet, considering that many employees emphasized the effectiveness of one-on-one reviews (which was also overall the second most listed practice) as it enabled them to discuss both different issues in an understanding and open environment, it may be possible to assume that these attribute to greater awareness in regards to employee MH. While participating employers did not specifically name one-on-one reviews, many did emphasize their open door policy and recounted informal conversations, in which employees shared information about their MH. Thus, it may be possible to conclude that regular one-on-one meetings as well as personal check-ins may not only attribute to greater awareness but also foster inclusion, as employees noted to feel encouraged to share “as long as there is a culture of supporting people living with mental health issues” – and therefore overall improve MH as proactive management is enabled. This furthermore can be linked to the finding that the management of MHCs in the workplace also has its limitations considering that – as underlined by one interviewee – managers and HR are not medical professionals and referral to such services may at some point become inevitable. Thus, it is possible to argue that increased awareness also increases the likeliness of employers to recognize when these steps are necessary.

In conclusion, having an open and supportive culture, along with flexible working arrangements and one-on-one meetings have been found to be most effective in relation to management of MH and wellbeing. As the importance of managerial support in connection to this has not only been outlined in literature but also by participating employers and employees, it will be discussed in more detail below.

5.3.1 Relevance of the Managerial Role
It has been outlined that both HR and line management play a crucial role in shaping an inclusive, open and supportive organization in relation to employee MH and wellbeing (Cunningham et al, 2004). While the findings support this idea with HR not only being largely involved in the drafting of P&Ps but also in the management of employees with a MHC – especially in cases of sickness absence –, research has also pointed to good line
management as the key determinant in how these P&Ps are implemented and in turn, how employee MH is managed (Munir et al., 2009; Woodrow & Guest, 2014).

The discussion above concerning factors determining the likelihood of speaking about MH in the workplace highlighted the significance of supportive management from employees’ perspectives. Looking at employers’ perceptions, the importance of having good (line) management was certainly mirrored with several interviewees underlining that good managers recognize changes in their employees and can hence intervene when they feel that MH may be poor. Yet, interviewees also recognized that this is not always easy and hence highlighted communication and experience as key. This is not only consistent which existent literature, which stresses the advantages of an attentive and supportive management (Munir et al., 2009; NICE, 2009), but also in line of employees’ responses praising both their manager’s approachability as well as regular check-ins – may they be formal or informal. Hence, this underlines that good management should consist of both, paying attention to employees in order to recognize changes while also enabling conversation to encourage sharing of possible MHCs.

Literature has outlined several reasons explaining managers’ inability ability to support employees with a MHC. One interesting reason being the double pressure they perceive as they have to juggle performance and productivity standards while also caring for their employees’ wellbeing (Cunningham et al, 2004). This factor was mentioned directly by two interviewees, one pointing out that their managers may sometimes be “pulled in different directions”. Nevertheless, it appeared that participating employers recognized their responsibility in having to support employees in order for them to perform well.

Interestingly, the majority of HR personnel understood their role as an advisory or coaching role to management, with only five participants saying that they offered some form of training to managers yet none of them saying it was mandatory. These findings certainly tie into the CIPD’s (2016) report of only 10% of UK employers noting to have specific line management training regarding management of employees with MHCs. While availability may thus be one criticism, findings of this research show that the trainings offered in fact target raising awareness – with the MH First Aid course in particular – which
stands in contrast to other research findings pointing to more procedural trainings (Woodrow & Guest, 2014).

While these findings may easily be interpreted positively, it is important to consider that participating employers have been in contact with the Social Enterprise and therefore may be more aware of the issue than the majority of employers. It is therefore also interesting to consider one expert’s perception, who offers specific management training courses and who underlined a lack of organizational commitment is evident in the fact that only rarely senior managers come along to the trainings. This certainly is consistent with research findings by Woodrow & Guest (2014), who also attributed lack of training to lack of motivation as it appears to not be prioritized by managers or the organization as a whole. This was also mirrored in other interviewees’ responses who stressed the importance of top-level commitment to combating MH problems in the workplace.

To conclude, while this study has found several employers to have managers acting as great role-models, who encourage discussion of MH in the workplace by being open about personal MH problems, it is vital to acknowledge that not all managers have this personal experience to draw from. Although other interviewees stressed the value of experience in managing employees with a MHC, it may be possible to assume that training should be considered more of a priority of the organization as a whole to ensure management commitment and as one interviewee put it: “It does pay and it probably will pay to invest in mental health a little more.“ (P3).

5.4. Limitations and Further Research Opportunities

Perhaps the main limitation of this research project was that research samples for both employers and employees were largely recruited through the Social Enterprise’s networks, which means that they showed an interest in the topic or have already worked with the Social Enterprise and were possibly more aware of the topic than the general public would be. In addition to this, respondents from the third sector made up nearly 50% of respondents and the vast majority was female. Against this background, it would be difficult to generalize this study’s findings (Bryman & Bell, 2015). Moreover, time restraints did not allow for an extensive volume of data collection. Thus, a limited sample was drafted, affecting the vigor of qualitative data and in turn possibly the validity
(Maxwell, 1992). Thus, a further study with a larger sample size is suggested to gain a better and more representative understanding of the issues discussed in this paper.

The concurrent mixed-methods approach may also be considered a limitation as collecting all data within one timeframe limited the opportunity to adjust research questions and as was not possible to analyse the impact of time upon the different measurable variables. Further research should therefore be undertaken to investigate changes in attitudes, employed P&Ps and other developments within the area.
6. Conclusion
This research project’s main objective was to gain a comparative understanding of employers’ and employees’ perceptions around how MH and wellbeing are being managed in their workplaces. Moreover, this research project sought to investigate a range of emergent themes, including the impact of MHS, factors determining the likelihood of disclosure, and the role of management in implementing effective P&Ps.

In order to meet the aim of this project, a concurrent mixed-methods research, consisting of interviews with employers and an online survey targeting employees, has been conducted.

The main findings of this research included the overall perception of both employers and employees, that an emphasis must be placed on having an open and supportive environment to enable a discussion MH in the workplace and decrease MHS. In relation to this, disclosure was discussed by several employers in the context of their inability to support employees without having the full information while acknowledging that it is every employees right to choose whether or not to disclose a MHC. In order to facilitate such a culture, findings were consistent with existing literature in as much as they underlined that organizational commitment and particularly line management support are essential in making MH a priority. Several employers also emphasized the positive impact of ‘role-modeling’ openness around MH to encourage employees to discuss possible MHCs as well as decrease MHS within organizations.

Albeit participating employers and employees largely remarked having a positive environment in relation to MH and wellbeing and levels of perceived support were overall high, it appears that there is still a lack of proper line management training – as for instance none of the employers who noted to offer training made these mandatory. This is also important in relation to the finding that despite being very aware of MHCs, stress and MHCs were largely recognized as interlinked. Thus, increasing training opportunities may also attribute to the recognition of MHCs as a matter that requires specific attention.

Perhaps the most significant limitation of this study – which also in part serves as an explanation of the results – was the likeliness of participants having a higher level of
awareness and familiarity with the overall topic than the general public considering they have been contacted through a Social Enterprise specializing in the field. Hence, further research in this field with a larger and diversified sample is recommended.

Nevertheless, the combination of both, employers’ and employees’ views, can be understood as a vital contribution to existent literature. By establishing a positive connection between openness and discussion of MH in the workplace, the findings of this research project offer a valuable insight into what employees perceive as effective and thus enable employers to address issues around MH and wellbeing strategically.

**6.1 Practical Recommendations and Implementation**

The findings of this research project – in support of existent research – have established the importance of an open and supportive culture in relation to fostering good employee MH and wellbeing. In relation to this, the importance of (top-level) management commitment and organizational transparency have been outlined.

The first practical recommendation of this study is for organizations to implement a specific MH and wellbeing policy in order to emphasize organizational commitment and increase transparency to allow the management of MH. This could in turn increase disclosure rates as employees know their rights and what steps employers will follow if they choose to open up about a possible MHC. In this case, the financial cost would be relatively low while a project team would have to be formed, research would have to be conducted and employee feedback would have to be gathered - hence a certain amount of time and effort would be required over the course of approximately one month. Figure 11 shows the implementation process in greater detail.
Secondly, this study has outlined the significant role of management not only in implementing P&Ps but also as they are in a position to recognize changes in their employees and therefore are capable of managing poor employee MH proactively – if trained properly. Thus, the second recommendation is to introduce training opportunities consistently throughout all levels of management to signal organizational commitment and increase overall awareness. To address attendance issues (Woodrow & Guest, 2014), it is recommendable to make training at least for some managers mandatory. One option would then also be to spread awareness by having participating managers share their knowledge in internal workshops, preferably in cooperation with HR. Thus, one preferable option would be to enrol managers selected by HR in *Mental Health First Aid* (MHFA) courses to build up capacity within their organizations. As illustrated in Fig 12, during a standard session, participants will learn how to spot early signs of MH problems, how to help and intervene and guide people to support as well as how to dispel MHS. This standard course typically costs around £300 per participant and runs over two consecutive days.
6.2 Personal Statement

Considering that my undergraduate program did not require me to collect primary data as part of my final thesis, this research project was the first time I applied a mixed-methods approach to research. It hence enabled me to explore both, a new scientific method as well as a topic of interest to me in depth. As this project was a company sponsored dissertation, it moreover allowed me to gain valuable, practical experience of working with a social enterprise and hence also enabling me to learn more about this field of work as well.

The learning experience as a whole was at times stressful, yet overall rewarding. I had the opportunity to interview not only three experts in the field, but also seven other HR or general (line) managers who provided me with valuable insights into their organizational P&Ps and attitudes towards MH and the workplace. This not only helped me understand the topic from a more practical stance but also fostered my networking and interviewing skills. Since I chose a mixed-methods approach, I also learned how to collect data with an online questionnaire and subsequently using a statistical software to analyze the responses.

Because the approach I chose was quite time-consuming, I also learned the value of time-management over the course of this project. By familiarizing myself with the research ahead of time, I was able to carefully plan the data collection in regards to the research questions I had drawn out. Early contacting of possible interview participants allowed for a timely scheduling of appointments over the course of a month. The distribution of the online questionnaire was aided by the support of the Social Enterprise, which led to a satisfying number of responses. Perhaps the only shortcoming of this experience was the
timeframe and context of this dissertation, which allowed for only a limited exploration of the topic despite very rich data.

During the process of this research project, I was able to learn an important lesson about organized and structured academic work and the satisfaction of gathering useful data. While there have been some limitations to this project – as outlined in the Discussion chapter – it is still expected that this dissertation contributes to research by exploring the treatment of MH in different workplaces with a specific focus on the role of stigma and a comparative look at both employers’ and employees’ views on the topic. Moreover, the findings discussed in this dissertation among with the recommendations ought to aid the Social Enterprise’s efforts in increasing wellbeing and mental health among the organizations that they work with.
7. Bibliography


8. Appendices

APPENDIX A

Technical Appendix

Awareness Index:
In order to measure employees' levels of awareness of MHCs, item Q9, which listed possible MHCs to be associated with the term ‘mental ill health in the workplace’ was computed into an ‘awareness-index’. The more MHCs participants checked on the list – which included 10 items plus one ‘other’ box, which was included in the index as it indicated further knowledge – the higher they scored on the index.

Scale 1: Organizational Support
The scale combined Items Q5-Q8, which asked respondents about perceived support and concern from colleagues and supervisors. These levels of support were measured on a Likert-Scale where 5 = strongly agree and 1 = strongly disagree. A high score equals high levels of support. Reliability has been tested in relation to Cronbach’s alpha \( \alpha \) and the result obtained was: \( \alpha = 0,741 \). Considering that reliability is proven with \( \alpha = >0.70 \), this scale was found adequate to use.

Factor analysis using Varimax rotation resulted in two factors, two items loading on each factor; yet considering that reliability was proven for this scale, it was deemed acceptable to use within this research project.

Scale 2: Stigmatizing Attitudes
The scale combined items Q10-Q13, with Q12’s values being reversed so that for all items, a low score would equal in low levels of stigmatizing attitudes. Items measured attitudes on a Likert-Scale from 1 (=strongly disagree) to 5 (=strongly agree). Reliability for this scale has been tested in relation to Cronbach’s alpha \( \alpha \) and resulted in \( \alpha = 0,739 \). Hence, the scale was found adequate. Factor analysis using Varimax rotation resulted in one dimension, hence granting validity for this scale.
APPENDIX B

Interview Questions

1) In your role as xx, what does mental health and wellbeing mean to you?
   a. is interviewee talking about stress or mental health?

2) How would you describe the organizational culture (in relationship to wellbeing and mental health)?
   a. probe for possible attitudes and stigma

3) What specific mental health conditions have you encountered in your workplace?
   a. What is your estimate on disclosure rate?
      i. What in your opinions are the factors that determine the likelihood of a disclosure?
   b. What is your opinion on discussion around concealment/disclosure?
   c. if cases of mental health issues in the workplace are mentioned: what accommodations have been made for affected employees?

4) Does your organization have a formal policy on mental health and wellbeing in the workplace? If so, what does it look like?
   a. how is organization distinguishing between wellbeing, stress and mental health?
   b. are these practices aimed at prevention measures or promotion of employee wellbeing?
   c. In your opinion, how does stigma tie into this?

5) To your knowledge, who was involved in the process of formulating these policies?
   a. What opportunities were given to employees to get involved?
      i. How were they informed?
   b. Was a survey conducted beforehand?
   c. Given the opportunity for feedback?

6) What is your perception of these policies and practices?

7) In your opinion, what seems to be employees’ perception of these policies and practices?

8) What training is offered to line managers? (if applicable)
APPENDIX C

Interview Transcription #1

I: In your role within your organization, what does mental health and wellbeing mean to you?

P1: In terms of mental health and wellbeing, mental health being something that, we all have mental health, you know. Some days our mental health is good, some days it can be poor and for us, it’s the tipping point between how you feel on a regular basis and how you feel when the poor mental health starts to take over from the good mental health. So, in terms of wellbeing, what we would hope is that people build up their resilience, that they have fulfilled lives, so that they have good mental health and wellbeing. We work a lot with people who have mental health problems, and who’ve recovered from fairly severe mental health problems so that they should have the opportunities to live as full lives as they are entitled to. It’s very much about looking after the rights of people with poor mental health and particularly around stigma and discrimination, which for them can either help or hinder their recovery. So that’s our main goal, is tackling stigma and discrimination in all its forms. So we have three priority areas, one is the workplace, the other one is children and young people and the other one is mental health and care places themselves, because the one thing that people with poor mental health have told us that those three areas as well as within their own families and friends, circles, are the areas in which they either most experience stigma and discrimination or where they would seek support.

I: Out of curiosity, children and youth, that would be with people of that age or would it be focusing on their peers.

P1: For children and young people, the program that we have has two elements, it does have a peer support and education group, which comes together and they’re developing their own program and then we’re also developing with them a path to secondary schools, high schools, which will be piloted in autumn.

I: Can you maybe go a little more into detail about what you do in the workplace? What your main programs are, initiatives maybe..

P1: In the workplace, we have a “see me at work” program, there are four stages within that – the first page is pretty basic, you just sign up on our homepage, on our newsletter, you get newsletter updates, the second stage really is where I come in and where we want workplaces to engage more with (programme) and look at how mentally healthy their workplace is and what kind of environment they work in. So we start by doing a mental health check to find out where the organization is at the moment. So we have a survey, which is an anonymous, confidential survey of five seconds, so we first of all look at the response rate..you know..the response rate in comparison to the number of employees they have in the organization. Then, we look at recruitment, so what are the areas where people who have tried to get back in the workplace have told us it is most difficult to get a foot in the door and to get through the interview stage. So we look at the recruitment stage and what kind of policies the organizations have in place – are they fair and equal for everyone? And the second stage we then go to look at is the workplace itself, so what kind of support...so the questions are all tickbox answers… so the questions that we would ask in the workplace would be things like ‘do you feel that you get the proper support from your manager, are the managers supportive? Do they know how to deal with someone with a mental health problem?’ We talk about that first conversation… Are you able to go speak to someone in the workplace or would you be concerned to speak to someone in the workplace for fear of losing your job, being passed over for promotion, being
moved to another post – that kind of thing. And we look at, do you feel, we always ask would you like a better understanding of mental health and with that we always get a yes, in all of the surveys we’ve done. So it’s about, is the workplace equipped to deal with mental health problems, do they know the right questions to ask, do they recognize the signs at an early stage? Before someone becomes very ill in the workplace so they can put in reasonable adjustments at an early stage that may help that person becoming very ill and may actually help that person to a quick recovery.

So there’s in work and then we look at training, what kind of training organizations offer around mental health. So we look particularly at managers, what training line managers have had and when they’ve had it...have they had any in the past three years. And we look at returning to work, going back into the workplace after a long period of ill health and the support that they should be offered and the support that they are offered when going back into the workplace, what kind of reasonable adjustments are put in place for them. I think it’s much more understood in terms of physical problems, what kind of reasonable adjustments are or can be made, maybe not so much in terms of mental health, what physical adjustments can mean to someone. And the last section really is about the whole culture of the organization, so it looks at the staff relations with their managers but also with their colleagues, so when someone has a mental health problem, are they included in the company culture, or do they find that they can be at times excluded or do they feel that they cannot talk mental health with their colleagues or again, what kind of reactions do they receive. And that’s all about, and people tell us..they quite often wait, they suss the place out first before they feel that they know if they would get a bad or a good reaction when they’re talking openly about their mental health.

I: You just hinted at that, but because disclosure is such a big topic, maybe in your experience with working with organizations and people who have been affected, can you see a trend of whether disclosure happens more so within employment or before people are employed?

P1: I think I would say probably, once they’re in the job. Through the interviews that we have done at the pre-employment stage, its all about what kind of questions they will be asked… so for example, when they’re filling in their application, very view of them actually tick that they have a disability, which they could do and it may actually help them get an interview but there’s still very few people at that stage who would to that openly. Again, in the interview, they’re…certainly in the public sector, the recruitment progress is very straight forward and very well known and followed to the latter, but there are ways for people can ask, for example if there’s a gap in your employment history, you could ask ‘what were you doing during that period of time?’ and then someone either needs to reveal that they were off with a long-term mental health illness or they’re faced with…and at that stage when people have done that, they saw the shutters come down with the recruitment panel so they’ve known almost immediately that by revealing that, they have lost their chances of getting the job. And for us, its very much about people’s rights, if you have the experience and the qualifications to do a job, that’s what you should be interviewed on, not on your medical history.

I: Coming back to culture, because you just hinted at that, how would you describe your organizational culture in relation, of course, to mental health and wellbeing?

P1: …That, what we are working in? (laughs) Ahh interesting! I think like many organizations, we put ourselves under a lot of stress I think, we put on, you know, we have huge workloads, we are a small team of 10 people and cover the whole of Scotland, there are many demands on us, on our time and on our funding. There are many pressures on us to deliver from our funders. I think we are not immune to… I would say we’re not the perfect organization but we also
recognize the field that we work in and we are supportive of each other but that doesn’t mean that we don’t hit periods of relative stress within the organization. But, you know, we’re a team that includes people with mental health problems, just like any other organization and we know how to support people, I believe we do have very good support from our managers, we do have a very good understanding of what mental health is so I think we are in a position to be able to say ‘I can’t keep on doing this’ and then we need to sit around and discuss it...we do get good support from our senior managers, which I think is probably the most important thing. I think in all organizations, the culture begins at top so that if the directors or senior managers aren’t on board or are putting lots of pressure on the line managers below them, the line managers won’t be able to support someone when they’re getting the pressures to perform themselves. From that perspective, we are a good team, we know how to come through the hard times but we are very aware also that everyone’s mental health within the team is different and sometimes, you know, people need extra support too.

I: Does your organization have a formal policy that everyone is aware of, on mental health in the workplace within your organization?

P1: (Title of organization) is part of (larger organization), so all our policies are (their) policies. They don’t have a mental health policy, they do have other policies which cover other things like stress, behavior and stigma. So like other organizations, they do have policies that cover areas of that but they don’t have mental health policy… which, for a mental health organization is a bit of a gap actually I think.

I: But you did mention support earlier so maybe you could give a little more detail on some of the practices that would be taking place or some accommodations that would be made…?

P1: There is an EAP and a counselling program if people want to access that for anything. I mean the procedure is really going around working with your line manager or if you can’t work with your line manager, then someone else from within the organization. What other HR policies….? Like every organization… I mean we’re a small organization really but (larger organization) has 700 employees and there are many policies on our intranet, how and when people access them is another story. And I think that goes for us as well. I think when developing our program I did look at (larger organization’s) policies and took some of them as well and some of them are quite good but there are things that could be tightened up a bit and I think they’re aware of that as well.

I: As you mentioned counseling, I was kind of..when I looked at the literature, there was a distinction between preventative measures and general promotion of wellbeing. Keeping that in mind…um is help mostly offered when things are already happening? When people are already too stressed maybe or is there a general promotion that is happening?

P1: I think that the services are there to help people at any stage. (pause) I think that people tend to wait until things get bad before they look to access those kind of services which is a bit of a shame I think because these services offer all kinds of advice when you’re having issues at home, for example…if you have financial issues…If you have cater(?) issues…you can go and speak to someone about it and I think for a workplace, its great to have these services in place. They’re actually a real bonus for people, particularly if you ARE ill and you go to the doctor and the doctor goes ‘I could offer you counselling’, and you go ‘Oh I could do the counseling’ but there’s a 16 week wait for the counselling while you can access it almost immediately through your workplace! And I think there’s not enough promotion within large organizations and (title of larger organization) is a large organization. We all have access to the (larger
organization’s) intranet, but you know… you have to hunt about a bit to find what you are looking for so I think there is room for more promotion that can be done… it’s always difficult I think in a large organization to find the best way to get that information to people and people are not interested when they’re well – that’s the problem you know? And they forget it’s there and then, when you start to become ill or when you’re starting to have some issues, you’re so caught up in them, it takes a while to get to that stage of…you know…recognizing that something can be done. And that’s where a good line manager comes in, when they’re able to recognize changes in someone’s behavior at an early stage, they can then prompt someone about the services that are available to them. I think, that’s one of the crucial things within the workplace, is line managers having the training to recognize changes and that might just be someone who is normally at their work early in the morning, they start coming in a bit later or looking a bit disheveled or tired, you know… just any kind of changes within their work pattern and whether that’s their performance or something else. That they’re confident and know how to approach someone and have a conversation about that. It’s very difficult to approach someone and say ‘you, know…I noticed you’re a bit… messy (laughs), you’re not as smart as you usually are , Is there something going on? Something you want to talk to me about?’ And there are good line managers who have had the training and I don’t really go along with the notion, that if you get a good , what they call ‘people-person-manager’, then you are lucky because for me, it doesn’t matter whether you’re that kind of person or not, what’s your personality is but whether or not you have that training and you’re able to do something and I think that’s where some managers fall short. They talk about performance, a lot of supervision sessions are all about performance, and at the end of the session, or the very first thing they might say is ‘how are you?.Ok well now let’s talk about this’ or in the end, they may say ‘is that it? Anything else you want to talk about? Ok right, see you in six weeks’ time’. And, I think there needs to be more build into that process, which is much more having a conversation… get to know the person you are managing!

I: speaking from your experience both here and in your work with organizations, what training is being offered to line managers?

P1: Hmmm…I think it’s quite patchy. Pause. So some people will get training in stress management…I think most organizations have stress management, that’s the one thing that concerns them most..their absence levels that are caused by stress and that’s the one area they look to cover. And some of them do mental health first aid training and others assist training…whatever training they can access for free is usually popular. It depends on what part of the organization, they might have a good training program otherwise it’s really, it can be very patchy.

I: Coming back to the practices and policies that you have here, that you already said come from further up, do you know in which ways employees were given opportunities to participate in the formulation of these practices and policies or giving feedback to these?

P1: In (title of organization) my understanding is that formulating the policies, it would be HR and the appropriate managers, senior managers but would also include some staff from some of the services. They try hard to have involvement and many of..I mean (organization) employs quite a high proportion of people with mental health problems and they would be involved in formulating some of these policies.

I: Are these getting reviewed?

P1: Yes, every policy has a review date on it.
I: Maybe, in your opinion, what seems to be your colleague’s perception of these p&ps? Do you ever talk about these?

P1: hmm… (pause) not really?... I mean, we’re quite a new team and…well it hasn’t come but I think because of my role and my manager’s role within the organization, we have a good understanding… (pause). We haven’t in the past 2,5 years, which is when we have been as we are right now, we haven’t sat around and had a conversation about what policies (larger organization) has (giggles) but you know, I think there is quite a strong awareness. We’re all aware for example of the equality act. We’re all aware of the equality act and what that says and because (we) work(s) within a human rights framework, we’re very aware of what human rights within a workplace look like and that’s our kind of guidance as an organization but also as our staff team…you know, we have to walk the walk, you know, as an organization, so in terms of (our organization), I think we do that pretty well.

I: One of your tools to administer general wellbeing within the organization is a survey?

P1: Yes, we do a survey and on completion of the survey, I would produce a report for the organization and that comes in a traffic light system. So each section is given a red, orange or green rating and the report would show that plus have some comments and recommendations at the end of that. And then I’d meet with the organization and from there, we would develop an action plan with the organization, picking maybe just two or three of the sections that they need most improvement and then looking at those and then building some kind of an action plan around that so that could be monitored and evaluated. And what we then would be looking for in the organization is some kind of behavioral change and now it takes quite some time to measure behavioral change... so we would want some of their actions to run over a good period of months and then do some initial evaluation and also see how things are carried through. So at the moment, we’re developing, we’ve developed some online training, that we’re going to pilot with some of the organizations we’re working with now and then gather some immediate response to that training and then go back in three months and see if they’ve implemented any of the learning and then again in six months and see, you know, has there been any kind of behavioral change. So that would be the kinds of things that we would be hoping for from these organizations.

I: And have you ever used that survey within your organization or the larger charity organization?

P1: Not yet… (laughs)

I: Maybe as a final question, just because you have been working in this field so long, have you noticed any differences when it comes to size or sector of an organization? Or how long they’ve been working together?

P1: It’s very varied I would say… (pause) I mean, I think there are themes that come out of the program, that are kind of common themes, these are around training, because I think there’s not enough specific training programs out there related to stigma and discrimination, which is why we’ve developed our own. (pause) the culture of the organization I think in the most…could do with a little improvement…

I: Can you elaborate on that?
P1: I think, just in general around support from managers, support from colleagues, being able
to talk to colleagues about it...that can be very mixed. And disclosure is the one that comes up
most negatively in a good number of the survey...not in all of them but a fair number of them.
Uhm, Recruitment and returning to work tend to get quite a good rating, I would say some of
the stuff in work, the culture, the training are the three, which are on different levels and in most
organization need the most attention. Some are quite good and some aren’t although I will say
very few come up with red ratings so I think most organizations are aware but you know, it’s
quite patchy...they’re not sure what to do and it’s quite patchy but I think workplaces are
beginning much more to recognize that there is an issue and it has an economic value attached
to it, so for us there is an economic argument and there is a moral argument in people not being
allowed to work in the workplace AND in fact that people are already in the workplace and
maybe they don’t recognize how many people with a mental problem already are in their
workplace. But I think the economic argument is becoming much stronger and organizations
are beginning to recognize it much more. So, we’re actually doing pretty well and been going
for a year now and in the past few months, we’ve been getting a lot of requests to work with
organizations so it’s still in the early stages but pretty good...it’s a big, I’m sure you’ve
discovered, it’s a big task and I think the two main areas to work with are human rights, and if
they have diversity and equality staff in the organization, they are much more supportive
because they deal with the issue a lot more than I think HR are.
I: In your role as a programme manager, what does mental health and wellbeing mean to you?

P7: I guess there’s a lot of focus on health and safety and, physical safety, and kind of group policy and all these things in the bank, especially because it is so big, they have to rely on all of this official training and control that all the people have done all the training that they’re supposed to do but there isn’t as much focus on mental health training. So the real training rather than focus on general employee wellbeing. For me, I’ve had personal experience at work and outside of work, of colleagues, of families – you know, some not that serious, just stress symptoms and things like that but different kind of mental health problems and I’ve seen also the benefits that I think some, what are called ‘mental health problems’, things like dyslexia, have actually helped those, have different talents that people who don’t have that have…so I’m really interested in helping colleagues or family members or whatever to make sure that they’re supported but actually looking at it from a different perspective and treating them kind of as a valuable member with skills to bring to the table that other people don’t have. And to understand how to support the team that actually works for me here at (the bank).

I: You’ve already hinted at a couple of things but maybe to go into a little bit more detail, how would you describe your organizational culture in relation to mental health and wellbeing?

P7: I think it’s actually improving day by day! I think that within (the bank and group) there is much more focus now on mental health in general – not so much on formal training like ‘mental health first aid’ but just making sure that there’s a focus on diversity and inclusion and that people have somewhere to go if they have problems so I think there’s quite a positive culture around it now than I would say was 10 years ago when I first started.

I: What specific mental health conditions have you encountered in the workplace?

P7: Stress, obviously (laughs)...left, right and center, myself included! Dyslexia...umm, not anymore but there was a gentleman who worked in our department at one point who was blind and I think with that kind of comes, not too much stress, but you know mental health aspects of that and feeling included and....um...and, not so much any more serious conditions like schizophrenia or such or clinical conditions...so more things like dyslexia, stress and depression...things like that.

I: In your experience, possibly with colleagues, what is your estimate on the disclosure rate of mental health problems within your organization? Is it something people feel comfortable talking about to their employer?

P7: No is probably the shortest answer...again, I do think it’s getting better as the company, and people put more effort into making people feel like there’s an environment where they can disclose but I still think that based on what I’ve hear – so we’ve got a network that is called ‘The Access Network’, which is a disability network, so that kind of covers disability but it also includes mental health within that and through the colleagues I know that are on the network, they’ve already said that it’s really difficult to actually get
people to sign up and disclose their disability or mental health condition...and to be a champion for other people visibly, so that obviously makes it really hard for other people to really tell how many people even have one.

I: What in your opinion would be the factors that would determine the likelihood of people disclosing a mental health problem?

P7: I think it’s still the perception of how they’re being treated, you know, so even though the company is trying to promote and change the way that people behave towards other people that have got mental health issues, I still think there are obviously pockets of people who are either consciously or unconsciously biased or would say things flippantly that would make other people uncomfortable and they don’t necessarily have that trust that they can say something and then still be treated equally or not be sort of penalized because of that.

I: You mentioned some experience with colleagues who suffered from mental health problems – can you think of any accommodations that have been made for people who have disclosed a mental health condition?

P7: Things like flexible working is probably the most obvious thing. Everyone is entitled to a flexible working pattern here, so you can agree a pattern with your manager to either work comprised hours or work remotely certain days of the week and I’ve certainly seen that help colleagues with stress and depression, so that they work a slightly different working pattern or work from home, so if that helps them, that has been introduced and in general, being very understanding – the company in general is very understanding with compassionate leave or sick leave and you know, if they aren’t well, letting them come back when they’re ready. That’s probably the main thing I would have said. Obviously with dyslexia and the other things I’ve said that have a mental health aspect to it, disability accommodations have been made.

I: Does your company have a formal policy on mental health or that covers mental health?

P7: Yes I believe so...um...there’s a gentleman I’ve actually put (MHScot) in touch with, whose name I forgot now (laughs)...who is working on the latest strategy for that and is now starting to roll out mental health first aid training as part of our kind of formal health and safety policy training.

I: You’ve already mentioned the network – can you think of other practices that would fall under mental health and wellbeing?

P7: So that network is part of a wider diversity and inclusion drive and initiative, that (the bank) is focusing on, so beside the disability network, there’s other minority networks – and will all that there’s obviously a mental health aspect to it, that we’re looking to make different minority groups feel included and look at things from different perspectives, so hopefully it’s part of that and that’s the main thing really.

I: Would you know if there are things like EAP or counseling?
P7: Yes, there is! Sorry, yes, there's an employee assistance program, and various things like whistle-blower-lines if you're not comfortable speaking to your line manager, you can take up these services.

I: That kind of what ties into what we've touched upon but to cover this again: how do you think the organization distinguishes between 'overall employee wellbeing', 'mental health' and 'stress'?

P7: Again, I think they are more now. In the past, we've always had health and safety riffs (?) and physical first aiders so that, you know, if something happens, there's someone around. It's only now that they're introducing training to have mental first aiders around, I think that's improving as well.

I: Since you have mentioned training, would you know what kind of training is offered to line managers in that respect?

P7: So, there's general training for everybody if you go looking for it...as I said now there's that first aider course. I am not a line manager, I matrix-manage people, so I don't know if there's something additional for line managers but I don't think so, I think it's the optional stuff that's available to everyone.

I: Going back to the policy and the practices, do you know who's involved in formulating these?

P7: Yes, that's the gentleman I mentioned, whose name I can’t remember (laughs), so we've got...there's obviously an HR department, which sets a lot of the policy but we've also got a responsible business department, who look at things like corporate social responsibility and things like that and within that one is the initiative and the specific teams that he's been appointed to, to look at mental health. So, that's I think is an extra focus beyond the kind of standard expertise within the HR team.

I: Are employees given the opportunity for feedback to your knowledge?

P7: There's lots of different avenues – if there's a specific drive, so we'll have something like 'mental health awareness week', then there's often an opportunity within that week to give feedback. There's things like the EAP or the whistle-blower-lines, and in general, different opportunities in general about how employees are feeling about general engagement, so I would say a lot of the times it's general feedback, not specifically asking for mental health feedback with the exception of specific initiatives like 'mental health awareness week'.

I: Maybe to sum this part up – what is your perception of the practices and policies in place?

P7: Erm...I think there's definitely a real, genuine effort rather than just ticking off a box now...you know, they are taking things seriously, like the mental first aid training, which shows me that they are taking it seriously. I think there's still pockets, where, you know, probably people who have never had any personal experience don't give colleagues the support that they need...you know, I'm sure that happens everywhere but overall, I think the company is trying.
I: How you say stigma ties into the whole topic?

P7: I still think stigma is attached to it – I think in general, that’s changing, in society people are becoming more – well (laughs), in most cases, not necessarily after brexit…at the moment, lovely display of horrible stuff (shakes head) – but you know, in general I think people are becoming more accepting of differences, including mental health things, or dyslexia or we’re aware of the impacts of stress and I think that’s kind of reflected here. So some of it I think is in the mind of the people who have mental health issues, the same as they say, men and women…you know those inequalities, part of it is women will not put themselves forward for things, you know, it’s as much in their heads as it is in the people around them. I think there’s an element of that, I think it’s about changing the mindset of the people that have the mental health issue as well as everybody else.

I: Do you have any additional comments, closing remarks you would like to make around the topic?

P7: I think probably the one thing that I’d like to see more of, that I don’t see a lot of people even acknowledge, is that not all mental health problems are ‘problems’, it’s not always about a sickness…sometimes it’s just about being different, you know, like dyslexia or you know, some of these things or spurges, they just think really differently and it’s sort of decided what’s normal and what’s not normal and determined the not normal as an illness or a disability and (pause) my husband’s dyslexic and which is where I’ve got sort of first hand experience with what that really means and it’s not just ‘aw, they can’t spell properly’ but to really understand how difficult it is for him and some of the mental health problems have been caused by how difficult it is for him to be treated the way he probably should have been treated at school etc. etc. …but I was so amazed by just the way his brain works, and there’s so many things he can do and I don’t think we celebrate people with mental health issues enough…it sounds kind of odd (laughs) but you know what I mean? It’s just that a different way of looking at things and we tend to see the negative and I think there’s so much more to be gained if we get the best out of people and we should focus on what they can bring and what other people cannot, the way that they can think.
APPENDIX D

Online Questionnaire

First Section: Aimed to get an understanding of your work environment

1) To your knowledge, what policies and practices does your organization have in place to promote and measure employee wellbeing and mental health? Please tick all that apply.
   a. One-to-one formal review meetings with employees
   b. Informal review meetings on an ad hoc basis
   c. Regular staff surveys to track wellbeing at work
   d. Hire external consultants to evaluate stress levels
   e. Regular assessments of absentee/sickness records
   f. Stress audit
   g. Access to counselling
   h. Flexible holiday policy
   i. Flexible working hours
   j. Working from home
   k. Stress awareness/management training
   l. General ‘wellbeing’ practices (ex. Gym membership, aerobic exercise, free massages…)
   m. Wellness Days
   n. EAP (Employee Assistance Programme)/Helpline
   o. Workshops on mental health and wellbeing
   p. None of the above
   q. Other

2) If you have participated in any of the practices in Q1, what did you find useful and why?
   a. SPACE

3) In case you have had experience with these policies and practices: In your opinion, do these practices and policies adequately distinguish between mental health, stress and general wellbeing?
   a. Yes
   b. No
   3b) Why?

4) In general, how do you find your job?
   a. Extremely stressful
   b. Stressful
   c. Somewhat stressful
   d. Not at all stressful

5) My colleagues are concerned for my wellbeing
   a. Strongly Agree
   b. Agree
   c. Undecided
d. Disagree  
e. Strongly Disagree

6) My supervisor is concerned for my wellbeing  
   a. Strongly Agree  
   b. Agree  
   c. Undecided  
   d. Disagree  
   e. Strongly Disagree

7) Overall, I consider my colleagues to be very supportive  
   a. Strongly Agree  
   b. Agree  
   c. Undecided  
   d. Disagree  
   e. Strongly Disagree

8) Overall, I consider my supervisor to be very supportive  
   a. Strongly Agree  
   b. Agree  
   c. Undecided  
   d. Disagree  
   e. Strongly Disagree

Section 2: This section will ask about your thoughts on MH

9) What specific health conditions do you think of when you hear the term ‘mental ill health in the workplace’? Please Select all that apply
   a. Anxiety  
   b. Depression  
   c. Manic depression/bipolar disorder  
   d. Stress  
   e. Substance abuse  
   f. Obsessive–compulsive disorder  
   g. Eating Disorder  
   h. Schizophrenia  
   i. Alzheimer’s  
   j. Post-traumatic stress  
   k. Don’t know  
   l. Other

Considering what you have associated with mental health conditions in the previous questions, please read the following statements carefully and select the answer that best describes your opinion

10) I would recommend a person with a mental health condition for a job
    a. Strongly Agree  
    b. Agree  
    c. Undecided
d. Disagree  
e. Strongly Disagree

11) I would not mind working with a person who has a mental health condition  
   a. Strongly Agree  
   b. Agree  
   c. Undecided  
   d. Disagree  
   e. Strongly Disagree

12) I believe people should try to conceal their mental health conditions at work  
   a. Strongly Agree  
   b. Agree  
   c. Undecided  
   d. Disagree  
   e. Strongly Disagree

13) I would trust a person with a mental health condition in a leadership position  
   a. Strongly Agree  
   b. Agree  
   c. Undecided  
   d. Disagree  
   e. Strongly Disagree

14) Would you feel comfortable speaking up about mental health conditions within your current organization?

15) If no: Can you explain why?  
   a. SPACE

16) Please read each of the following statements carefully. After you have read all the statements below, please choose all statements that depict your exposure to persons with a mental health condition. Mental health condition here relates to mood disorders, anxiety and depression.  
   a. I have watched a movie or a television show, in which a character depicted a person with a mental health condition  
   b. My job involves providing services/treatment for persons with a mental health conditions  
   c. I have observed, in passing, a person I believe may have had a mental health condition  
   d. I have observed persons with a mental health condition on a frequent basis  
   e. I have a mental health condition  
   f. I have worked with a person who has had a mental health condition at my place of employment  
   g. I have ever observed a person that I was aware had a mental health condition  
   h. My job includes providing services to persons with a mental health condition  
   i. A friend of the family has a mental health condition  
   j. I have a relative who has a mental health condition  
   k. I have watched a documentary on television about mental health conditions  
   l. I live with a person who has a mental health condition
Section 3: Personal Information – Please note that while some may be considered sensitive data, all information we collect will be completely anonymous and while it will not be connected to you personally, it will help us interpret the previous answers.

17) Please indicate your gender
   a. Female
   b. Male
   c. Prefer not to say

18) Please indicate your age
   a. 20-24
   b. 25-30
   c. 31-40
   d. 41-50
   e. 51-60
   f. 61 or older
   g. Prefer not to say

19) Please select the sector, in which you are currently employed
   a. Private
   b. Public
   c. Third
   d. Not applicable

20) Please select the size of your organization
   a. <10 employees
   b. <50 employees
   c. <250 employees
   d. <600 employees
   e. 600+ employees

21) Have you ever disclosed a mental health condition to an employer?
   a. Yes
   b. No

22) If yes: When?
   a. Pre Employment
   b. During Employment